An Analysis and Evaluation of Certificate of Need Regulation in Maryland

Working Paper: Inpatient Psychiatric Services

MARYLAND HEALTH CARE COMMISSION
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I. INTRODUCTION

A. Purpose of the Working Paper

With the 1999 passage of House Bill 995[1], the General Assembly required the Maryland Health Care Commission to examine the major policy issues of the Certificate of Need process, and to submit an interim report by January 1, 2001[2], followed by a final report by January 1, 2002. The Commission embarked upon a two-year process during which it would develop a series of working papers examining specific issues and implications of changes to the CON model of regulation. Inpatient psychiatry is one of the medical services defined in Commission statute, at Health-General Article 19-123(a), as requiring a Certificate of Need to establish and, in some cases, to expand once established. This report examines the current policy and regulatory issues affecting inpatient psychiatric services, and outlines several alternative options for changes to the Certificate of Need program and their potential implications.

B. Invitation for Public Comment

The Commission invites all interested organizations and individuals to submit comments on the options presented in this working paper. Written comments should be submitted no later than ***Monday, July 23, 2001*** to:

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C. Organization of the Working Paper

This paper is organized in four major sections. Following this introduction, Part II of the paper contains an overview of inpatient psychiatric services in Maryland, which characterizes the service according to its various settings, and provides both an inventory of existing providers and data on utilization trends. Part III describes the functions of the state government agencies with regard to their authority over inpatient psychiatric services, and Part IV describes how other states with Certificate of Need programs regulate inpatient psychiatric services. Part V of the paper outlines alternative regulatory strategies for the State – continuing, changing, or discontinuing Certificate of Need regulation of these services -- that reflect different assumptions about the role and ability of government, and of the market for health care services, to rationally allocate a crucial service and to protect the public interest.

[1] Chapter 702, Acts of 1999.
[2] *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Phase 1 Report to the General Assembly*, available on the Commission's website, www.mhcc.state.md.us.

II. MARYLAND HOSPITAL INPATIENT PSYCHIATRIC SERVICES: OVERVIEW

A. Supply and Distribution of Inpatient Psychiatric Services

In Maryland, inpatient psychiatric services[3] are provided in hospital settings, either in a designated psychiatric service within an acute general hospital, under the hospital's acute care license, or in freestanding private or State hospitals, whose beds are "special hospital" beds, under the licensing statute.[4] The interaction of several developments in psychiatry – an astounding array of new, more effective drugs to treat persistent and serious mental illnesses, the advent of managed care and its effect on both reimbursement and treatment decisions, and continuing legal and budgetary pressures to move patients to "the least restrictive setting" care for the mentally ill in the community – has had a significant impact on both the supply and distribution of inpatient psychiatric services, and on their utilization..

Inpatient psychiatry is one of the medical services defined in Commission statute, at Health-General Article 19-123(a), as requiring a Certificate of Need to establish and, in some cases, to expand once established.[5] Inpatient psychiatric care involves crisis intervention, diagnosing and understanding the manifestations of mental disease in the patient, developing an ongoing plan of treatment designed to minimize critical episodes and to promote the patient's ability to live and function in the community. The State Health Plan establishes the Commission's planning and regulatory framework around three designated divisions: psychiatric beds and services for adults; children to age 12; and, adolescents, between the ages of 13 and 17.[6]

The three categories of hospitals in which inpatient psychiatric services are provided in Maryland share a basic similarity: all three can provide a full range of inpatient psychiatric care -- though factors related to the source and level of reimbursement for services at each of the three hospital settings tend to determine where an individual patient will be admitted and cared for. More pronounced, however, are the contrasts between the three kinds of hospitals providing inpatient psychiatric services, in where patients come from, their average lengths of stay, and the cost of their psychiatric care, as well as in the reimbursement-related areas such as the impact of managed care and of the two primary payment systems.

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[3] Inpatient psychiatric services provided to patients with a "mental disease or emotional disorder" include Diagnosis Related Groups (DRGs) codes 424 to 428 and 430 to 432.

[4] At Health-General Article §19-307, Annotated Code of Maryland.

[5] HB 994, also enacted in 1999, prohibits the creation of waiver, or "creep" beds in acute general hospitals, but established in law an annual calculation of hospital licensed capacity, based on a number equal to 140% of the last full twelve months of occupancy data, as determined by the Health Services Cost Review Commission. The implementation of this provision, in the context of an existing provision in Commission statute, permits hospitals to reconfigure their bed capacity among their existing medical services. Consequently, acute general hospitals with psychiatry services may increase or decrease the service's bed complement at the time it allocates its approval total by service. Freestanding private and State psychiatric hospitals, whose beds are licensed as "special hospital-psychiatric," may still request the Commission to authorize waiver beds according to the statutory time frames and percentages.

[6] For the purpose of the present study, Staff will consider child and adolescent inpatient psychiatric services, as well as residential treatment centers for seriously emotionally disturbed children and adolescents, in a separate working paper, scheduled for release in September 2001.

Table 1 below presents a categorical summary of the distribution throughout the State of inpatient psychiatric bed capacity, by health planning region and by county. Even at first glance, the relatively small number of remaining private psychiatric hospitals is evident, as is the concentration of State hospital beds in the Central Maryland counties.[7] Inpatient psychiatry beds in acute general and in private psychiatric hospitals are similarly concentrated in the State's central core. The widest distribution and most ready geographic access is to the beds in acute general hospitals designated for inpatient psychiatric services, which are available in hospitals in sixteen of 24 Maryland jurisdictions.

Table 1
Inpatient Psychiatric Bed Capacity by Health Planning Region and County, 2000

Region/County	Acute general hospitals	Private hospitals	State hospitals	TOTAL
Western Maryland	**67**	**65**	**721**	**853**
/Allegany	17		119	136
/Carroll	20		602	622
/Frederick	15			15
/Washington	15	65		80
Montgomery	**91**	**87**	**0**	**178**
Southern Maryland	**94**	**0**	**0**	**94**
/Calvert	12			
/Prince George's	70			
/St. Mary's	12			
Central Maryland	**394**	**526**	**1,193**	**2,113**
/Anne Arundel	14		346	360
/Baltimore City	298		108	406
/Baltimore County	58	322	739	1,119
/Harford	10			10
/Howard	14	204		218
Eastern Shore	**46**	**34**	**144**	**224**
/Cecil	9			
/Dorchester	20	15	80	
/Kent			64	
/Somerset		19		
/Wicomico	17			
TOTAL	**692**	**712**	**2,058**	**3,462**

Source: Maryland Health Care Commission Hospital Licensure Database and facility licenses

- **Inpatient Psychiatry in Acute General Hospitals**

The twenty-eight Maryland hospitals with a designated inpatient psychiatry service operate a total of 692 beds, shown by planning region, county, and hospital (and system affiliation, if applicable) in Table 2, below.

[7] This concentration would be even more pronounced if, as in most regional breakdowns, Carroll County were considered as part of Central Maryland; this would shift the 602 beds at Springfield Hospital from Western Maryland, where Carroll's county government chose in 1988 to affiliate for health planning purposes, to the metropolitan Baltimore region, increasing its total to 1795 State hospital beds, or more than 87% of the total.

Table 2
Location, System Affiliation, Service Divisions, and Number of Licensed Beds, Psychiatry Units in Maryland Acute General Hospitals, 2000

Planning Region/ Jurisdiction	Hospital	System Affiliation	Child & Adoles.	Adult	TOTAL
Western Maryland				**67**	**67**
Allegany	Sacred Heart Hospital	Western MD Health System		17	17
Carroll	Carroll County General Hospital			20	20
Frederick	Frederick Memorial Hospital			15	15
Washington	Washington County Hospital			15	15
Montgomery County				**91**	**91**
	Montgomery General Hospital			27	27
	Suburban Hospital			24	24
	Washington Adventist Hospital	Adventist Healthcare		40	40
Southern Maryland			**7(a)**	**87**	**94**
Calvert	Calvert Memorial Hospital			12	12
Prince George's	Laurel Regional Hospital	Dimensions Healthcare	7(a)	11	18
	Prince George's Hospital Center	Dimensions Healthcare		27	27
	Southern MD Hospital Center			25	25
St. Mary's	St. Mary's Hospital			12	12
Central Maryland			**27(c)**	**367**	**394**
Anne Arundel County	North Arundel Hospital	Univ of MD Medical System		14	14
Baltimore City	Bon Secours Hospital			33	33
	Johns Hopkins Bayview	Johns Hopkins Health System		20	20
	Johns Hopkins Hospital	Johns Hopkins Health System	15(c)	88	103
	Maryland General Hospital	Univ of MD Medical System		28	28
	Mercy Medical Center			4	4
	Sinai Hospital of Baltimore	LifeBridge Health		24	24
	Union Memorial Hospital	MedStar Health		26	26
	University of Maryland Hospital	Univ of MD Medical System	12(c)	48[8]	60
Baltimore County	Franklin Square Hospital Center	MedStar Health		24	24
	St. Joseph Hospital			34	34
Harford	Harford Memorial Hospital	Upper Chesapeake Health		10	10
Howard	Howard County General Hospital	Johns Hopkins Health System		14	14
Eastern Shore				**46**	**46**
Cecil	Union Hospital of Cecil County			9	9
Dorchester	Dorchester General Hospital	Shore Health System		20[9]	20
Wicomico	Peninsula Regional Med Center			17	17
TOTAL			**27(c) 7(a)**	**658**	**692**

Perhaps the most immediately apparent detail provided by Table 2 is the extremely small number of designated child and adolescent beds in acute care hospitals across the State, less than one-half of one percent of the total. The twenty-seven child beds are concentrated in Baltimore City, at Johns Hopkins and University of Maryland Hospitals, with only seven designated adolescent beds, at Dimensions' Laurel Regional Hospital in Prince George's County and the

[8] Twenty of the 48 adult psychiatry beds at the University of Maryland Hospital are designated as "geriatric."
[9] According to a condition placed upon the Certificate of Need approval of its psychiatry service, Dorchester general Hospital may admit adolescents into a maximum of 25% of its adult bed capacity, or 5 beds, provided that the adolescent patients remain physically and clinically separated from the adult population.

potential to use five adult beds at Dorchester General Hospital in Cambridge, provided by a Certificate of Need-related condition.

Two provisions enacted in 1999 as part of HB 994, the Hospital Capacity and Cost Containment Act, have emerged as potentially significant factors in the future supply and distribution of inpatient psychiatry beds in acute general hospitals. The first is the annual recalculation of hospital licensed bed capacity, which now requires a yearly adjustment to the number of licensed beds each acute general hospital is permitted to have during the next fiscal year. The Commission works with the Office of Health Care Quality to determine the overall bed capacity each hospital will have for the next year, based on applying a factor of 140% of the average daily census from the last twelve months of complete occupancy data to the hospital's current bed capacity.[10] Given the next year's capacity figure, each hospital may reallocate the number of beds among its existing medical services, according to previous experience or projected changes in utilization.[11] This provision of HB 994 took effect on July 1, 2000, and was first implemented in October of that year. Table 3 below illustrates the results of the first re-calculation of licensed hospital bed capacity, both the change in total capacity and the change in each hospital's allocation of beds to its psychiatry service.

[10] As Commission Staff described in the "fact sheet" presented to the Commission on October 25, 2000 and subsequently posted on the MHCC website, the implementation of this provisions is a cooperative effort: the Health Services Cost Review Commission provides the data on which the annual calculation is based; the MHCC reviews and approves the hospitals' designation of the new bed total by existing medical services and maintains a Hospital Inventory Database; and OHCQ issues the revised license total, as a letter to be attached to each hospital's current license, since the actual license is only issued once every three years, to coincide with the survey and re-accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

[11] This reallocation is permitted through an existing provision in Commission statute, originally enacted in 1988 and further clarified in regulation, that permits increases or decreases in the bed complement of an existing medical service in an acute general hospital, as long as the total bed capacity does not increase, "and the change is maintained for at least one year" unless modified by the approval of a Certificate of Need (or for a merged system, an exemption from Certificate of Need), or by a change made during the annual calculation itself. §19-123 (h)(2)(ii), COMAR 10.24.01.02A(3)(b).

Table 3
HB 994-Related Increases or (Decreases) in Beds, Hospitals with Designated Psychiatric Units, 1999 to 2000

Jurisdiction/ Local Health Planning Area	Hospital	Total Licensed Beds			Psychiatric Beds		
		2000	1999	Change	2000	1999	Change
Allegany	Sacred Heart Hospital	145	240	(95)	17	27	(10)
Carroll	Carroll County General	166	168	(2)	20	20	0
Frederick	Frederick Memorial Hospital	241	228	13	15	15	0
Washington County	Washington County Hospital	223	266	(43)	15	17	(2)
	WESTERN MARYLAND TOTAL	775	902	(127)	67	79	(12)
Montgomery	Montgomery General	140	213	(73)	27	39	(12)
	Suburban Hospital	217	338	(121)	24	24	0
	Washington Adventist	344	290	54	40	41	(1)
	MONTGOMERY COUNTY TOTAL	701	841	(140)	91	104	(13)
Calvert	Calvert Memorial Hospital	88	139	(51)	12	28	(16)
Prince George's	Laurel Regional Hospital	109	174	(65)	18	26	(8)
	Prince George's Hospital	276	447	(171)	27	65	(38)
	Southern Maryland Hospital	221	350	(129)	25	34	(9)
St. Mary's	St. Mary's Hospital	84	107	(23)	12	15	(3)
	SOUTHERN MARYLAND TOTAL	778	1,217	(439)	94	168	(74)
Anne Arundel	North Arundel Hospital	231	312	(81)	14	19	(5)
Baltimore County	Franklin Square Hospital	299	383	(84)	24	36	(12)
	St. Joseph Hospital	308	434	(126)	34	19	15
	Total	607	817	(210)	58	55	3
Baltimore City	Bon Secours Hospital	147	208	(61)	33	33	0
	Johns Hopkins Bayview	296	306	(10)	20	20	0
	Johns Hopkins Hospital	922	989	(67)	103	115	(12)
	Maryland General Hospital	154	243	(89)	28	44	(16)
	Mercy Medical Center	211	285	(74)	4	8	(4)
	Sinai Hospital of Baltimore	350	368	(18)	24	24	0
	Union Memorial Hospital	247	349	(102)	26	26	0
	University of Maryland	629	724	(95)	60	72	(12)
	Total	2,956	3,472	(516)	298	342	(44)
Harford	Harford Memorial Hospital	102	283	(181)	10	25	(15)
Howard	Howard County General	167	233	(66)	14	35	(21)
	CENTRAL MARYLAND TOTAL	4,063	5,117	(1,054)	394	476	(82)
Cecil	Union Hospital of Cecil	98	166	(68)	9	15	(6)
Dorchester	Dorchester General Hospital	65	95	(30)	20	20	0
Wicomico	Peninsula Regional	305	300	5	17	17	0
	EASTERN SHORE TOTAL	468	561	(93)	46	52	(6)
	MARYLAND TOTAL	6,785	8,638	(1,853)	692	879	(187)
	Percent Change			-21.45%			21.27%

Source: MHCC Hospital Inventory Database

The second provision of HB 994 that could affect the supply and the geographic distribution of inpatient psychiatry beds in acute general hospitals is the change in law related to the "closure of a hospital or part of a hospital." Since landmark legislation aimed at health care cost containment and the reduction of excess hospital capacity was enacted in 1985, hospitals in Maryland have not required a Certificate of Need to close. Instead, any hospital could seek an exemption from CON to close either its entire facility or an individual medical service; with the required 45-day notice, the Commission "in its sole discretion" would approve the proposed closure if it were found "not inconsistent with" the State Health Plan, and in the public interest.

HB 994 removed even the need for an exemption finding by the Commission for closures proposed by hospitals in jurisdictions with three or more hospitals, and for all State hospitals, provided that the hospital notified the Commission 45 days in advance of the proposed closure, and, in consultation with the Commission, held a public informational hearing in the affected area.[12] In counties with only one or two hospitals, the previous requirement – for an exemption from Certificate of Need granted by the Commission – continues in the law. A situation related to this provision that has not arisen, but could potentially become an issue: what procedure applies – and what are the policy implications – if, in one of the jurisdictions where medical service closures require no Commission action, all but two psychiatry services would be closed, particularly if more than three hospitals remain? Given that no explicit rule prohibits allocating all of an existing service's beds to another service category, the potential for hard-pressed hospitals to discontinue any of its services is presented under these two provisions. Increasing financial and work force pressures may produce some of these hard choices, with obvious implications for access to the medical service in question.

The 18 acute general hospitals in Maryland that currently do not operate a designated psychiatric unit are listed in Table 4. These hospitals are located throughout the State, and include six in single-hospital jurisdictions. Of the eighteen, four facilities are in Baltimore City, three are on the Eastern Shore, four are in the Baltimore metropolitan area, four are in counties surrounding Washington D.C., two are in Western Maryland and one is in Southern Maryland. Eight of the 18 hospitals that do not presently offer psychiatric services are members of multi-hospital systems with psychiatric services available at one or more other member institutions. Anne Arundel Medical Center and Holy Cross Hospital formerly operated designated psychiatry services, but sought and received Certificate of Need exemptions from the former Health Resources Planning Commission to close the units.[13]

[12] At §19-123(l); Church Hospital in Baltimore City, which provided the Commission with its notice of intent to close on the effective date of the new law, October 1, 1999, has been the only hospital to close under this provision.
[13] Anne Arundel Medical Center received an exemption from Certificate of Need review to close its psychiatry service in October 1993; Holy Cross Hospital received an exemption to close its unit in April 1999.

Table 4
Maryland Acute General Hospitals Without Psychiatric Services[14]
June 2001

Hospital Name	Jurisdiction	System Affiliation
Anne Arundel Medical Center	Anne Arundel County	
Atlantic General Hospital	Worcester County	
Civista Medical Center	Charles County	
Doctors Community Hospital	Prince George's County	
Fort Washington Hospital	Prince George's County	
Garrett County General Hospital	Garrett County	
Good Samaritan Hospital	Baltimore City	MedStar Health
Greater Baltimore Medical Center	Baltimore County	
Harbor Hospital Center	Baltimore City	MedStar Health
Holy Cross Hospital	Montgomery County	
Kent & Queen Anne's Hospital	Kent County	
Kernan Hospital	Baltimore City	University of Maryland
Memorial of Cumberland	Allegany County	Western Maryland Health System
Memorial of Easton	Talbot County	Shore Health System
Northwest Hospital Center [15]	Baltimore County	LifeBridge Health
St. Agnes	Baltimore City	
Shady Grove Adventist	Montgomery County	Adventist Health Care
Upper Chesapeake Medical Center	Harford County	Upper Chesapeake Health

Source: Maryland Health Care Commission Hospital

- **Inpatient Psychiatry in Private Psychiatric Hospitals**

Maryland's private psychiatric hospitals provide care to patients needing inpatient mental health care, longer-term, so-called "residential" mental health services, services in a partial hospitalization program, and inpatient crisis and respite services. These hospitals used to be distinguished from their acute general hospital counterparts by a significantly longer average length of stay, but managed care has closed this gap significantly over the past several years. The most important distinction between the two settings remains: acute general hospitals can provide the full range of medical services in addition to psychiatric care, whereas the "special" license limits the private hospitals to psychiatric care only.

The supply of inpatient psychiatry beds in the State's freestanding private psychiatric hospitals has been dramatically altered over the last four to five years by bankruptcy-driven closures of several units and facilities, and the surviving four hospitals continue in varying levels of financial distress. A senior official of one facility early this year estimated that the then-five

[14] McCready Hospital in Crisfield, Somerset County, is the only Maryland acute general hospital with special hospital psychiatric beds, a total of 19 beds for long-term geriatric patients, relocated to McCready from the Eastern Shore Hospital Center in Cambridge via a June 1988 Certificate of Need granted by the former Health Resources Planning Commission.

[15] On June 16, 2000, the Commission approved an exemption from Certificate of Need review permitting Northwest Hospital Center to establish a twelve-bed psychiatry unit using beds relocated from its LifeBridge Health System partner, Sinai Hospital of Baltimore. At its meeting on June 6, 2001, the Health Services Cost Review Commission established a rate for the new psychiatric service at Northwest, effective August 1, 2001.

private hospitals would sustain a $7 million loss over the present fiscal year.[16] As with other supply-related issues affecting psychiatry services, the reasons for this situation are many and interrelated. Managed care restrictions on utilization of inpatient services, since a higher percentage of private hospital patients may (at least initially) have some level of health insurance coverage, is one important factor, as is the currently-mandated method of reconciling Medicaid payments and actual costs retroactively, a requirement of the federal Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA, which often results in the private hospitals owing money to the Medical Assistance program for care provided years before.

Table 5
Location, Service Divisions, and Number of Licensed Beds,
Maryland Private Psychiatric Facilities, 2000

Facility and Jurisdiction	Licensed Child & Adolescent Beds	Licensed Adult Beds	Total Licensed Beds
Brooklane Health Services, Washington County	27	38	65
Potomac Ridge Center, Montgomery County	43	44	87
Sheppard Pratt Hospital, Baltimore County	96	226	322
Taylor Manor Hospital, Howard County	77	127	204
TOTAL	**243**	**435**	**678**

Source: Maryland Health Care Commission files, facility licenses

There are currently four private psychiatric hospitals operating in Maryland.[17] Two of the hospitals are located in central Maryland: Sheppard and Enoch Pratt Hospital, a 322-bed hospital located in Towson, Baltimore County, and Taylor Manor Hospital, a 204-bed hospital located in Ellicott City, Howard County. Brooklane Health Services is a 65-bed facility located in Hagerstown, in Washington County. Potomac Ridge Treatment Center is a 87-bed facility located in Rockville, in Montgomery County, which faced bankruptcy and imminent closure when the Adventist HealthCare System acquired the facility from Charter Behavioral Health System in May, 2000.[18]

Two private psychiatric hospitals have closed as a result of bankruptcy filings in the past several years. The Gundry-Glass Hospital in southwest Baltimore City closed its 29 child psychiatry beds without notice to the former HRPC in August of 1997, claiming that the Medical

[16] "19.4% rate boost advised for Taylor Manor," M. William Salganik, *The Sun*, February 8, 2001, pp. 1-2C.

[17] Chesapeake Treatment Centers, Inc. (CTC) received a Certificate of Need in 1996 to establish a private psychiatric hospital treating children (8 beds) and adolescents (7 beds) in Cambridge; the beds were delicensed when the hospital, as well as a residential treatment center operated by the same company, lost its interim location on the grounds of the Eastern Shore Hospital Center in April 1999, and have not operated since that time. CTC has indicated to the Commission and to the Office of Health Care Quality that it plans to begin operating the beds again, which it must do by August 5, 2001 or face losing the authority to operate them, pursuant to Commission regulations effective February 5, 2001 that limit the amount of time a health care facility can maintain bed capacity that is not licensed and operating.

[18] Avram Goldstein, "Adventist Acquires Bankrupt Psychiatric Hospital," *Washington Post*, May 23, 2000, Metro, B2. The sale of Potomac Ridge was part of the overextended Charter system's sale of assets across the country, following its Chapter 11 filing.

Assistance program had not paid for millions of dollars' worth of psychiatric care. In October 1997, Gundry-Glass finally informed the HRPC that it had "suspended" its child inpatient unit, and that it was moving the adolescent and adult beds it had operated at Harbor Hospital to the Wickham Road site, which could physically accommodate only 29 of the 55 beds. By February 1998, Gundry-Glass had declared bankruptcy and closed.[19]

The most recent closure occurred in late April of this year, when CPC/Chestnut Lodge, operated by CPC Health, resolved its bankruptcy proceeding by ending services effective April 27, 2001, and selling the 110 special-hospital psychiatric beds to Sheppard Pratt Health System. Since the extensive property in Rockville occupied by Chestnut Lodge, the Rose Hill residential treatment center, and various outpatient buildings was sold separately, Sheppard Pratt has a year from the acquisition date to develop the beds in Montgomery County, under the Commission's regulations governing off-line bed capacity.

- **Inpatient Psychiatry in Mental Hygiene Administration Hospitals**

The Mental Hygiene Administration, a division of the State of Maryland Departmental of Health and Mental Hygiene, is responsible for overseeing the delivery of public mental health services in the State, including the operation of the eight State psychiatric hospitals, whose location, services, and operating versus licensed bed capacity are shown on Table 5.

Table 6
Location, Service Divisions, and Number of Operating and Licensed Beds,
State Mental Hygiene Administration Hospital Centers, 2000

Facility and Jurisdiction	Child	Adolescent	Adult	Geriatric	Forensic	Operating Beds	Licensed Beds
Clifton T. Perkins Hospital, Anne Arundel County			✔		✔	197	310
Crownsville Hospital Ctr., Anne Arundel County		✔	✔	✔	✔	243	264
Eastern Shore Hospital Ctr., Dorchester County			✔		✔	80	80
Springfield Hospital Ctr., Carroll County			✔	✔	✔	301	602
Spring Grove Hospital Ctr., Baltimore County			✔		✔	295	639
Thomas B. Finan Center, Allegany County		✔	✔	✔	✔	119	119
Upper Shore Health Center, Kent County			✔			64	64
Walter P. Carter Center, Baltimore City			✔		✔	50	108
TOTAL						1,349	2,186

Source: Mental Hygiene Administration

The supply and distribution of State hospital beds is, of course, directly tied not only to MHA's dedication to treating people in the "most appropriate, least restrictive setting" – a

[19] The Sheppard and Enoch Pratt Foundation acquired the Wickham Road site and the 29 beds, allocated as 15 adult and 14 adolescent, in December 1998, and had intended to re-implement the adolescent beds at the Gundry-Glass facility. However, by letter of October 31, 2000, Sheppard Pratt relinquished all 29 beds.

principle further supported by the Supreme Court's *Olmstead* ruling – but also to the State budget. Downsizing MHA's hospital system has been an explicit State policy since the 1984 development of the first five-year "Master Plan for the Deinstitutionalization of Chronically Mentally Ill in Maryland." The eight Mental Hygiene Administration hospitals occupy a total of 279 buildings on 2,515 acres, although currently only 172 of the buildings and just over 1,567 acres are currently in active use for the provision of inpatient and related outpatient psychiatric services. The impetus to reduce the bed capacity of MHA's hospitals -- and to divest the State of the aging buildings and commercially-valuable real estate – continues; task forces and legislatively-mandated status reports periodically examine the continuing need for public beds, and report on their use.

The most recent examination of the supply and geographic allocation of State psychiatric beds was mandated in the Report of the Joint Chairmen of the Senate Budget and Taxation and the House Appropriations Committees of the 1998 Session, which added language to the FY 1999 budget explicitly stating the intent of the legislature that "the Mental Hygiene Administration continue its efforts to downsize existing state facilities or identify at least one or two State operated mental hospital(s) to be closed within two years . . . ." A preliminary report submitted on December 1, 1998 presented the results of a survey of patients in the State hospitals, with an assessment of the kinds of community-based services that would be needed to further reduce the population at the eight State facilities, and of the number and configuration of the beds still needed. The final report to the budget committees, in July 1999, recommended the reduction of State hospital beds by more than half over the next five years, and a significant scaling back of the acreage occupied by hospital operations at the three large central Maryland campuses.[20] However, the report's introduction recognized that "the closing of a State psychiatric hospital is a controversial issue," noting that an initial recommendation to convert the Upper Shore Hospital Center to a residential program for the dually-diagnosed was rescinded "to preserve local access to State inpatient psychiatric services to residents of the upper Eastern Shore counties."

B. Trends in the Utilization of Inpatient Psychiatric Services

The same factors shaping the supply of inpatient psychiatry beds in Maryland have affected their use. Perhaps more than in the past, the issues and challenges faced by each setting have consequences for the others. MHA's interim Joint Chairmen's Report noted in December 1998 that the three central Maryland hospitals had been operating over budgeted capacity, but could not expect "significant relief" from the private sector, since it was also coping with increased admissions in a downsized system.[21] The pressure on State hospitals has continued, for reasons related to the growth in managed behavioral health care, and the pressures being exerted on utilization and revenues in each of the three hospital settings.

[20] *Final Report to the Joint Chairmen: The Statewide Needs Assessment for mental health Services and Mental Hygiene Administration's Five Year Plan for Downsizing and Consolidating of State Psychiatric Hospitals*, July 1999, pp. 2-3.

[21] *Report to the Joint Chairmen on the Statewide Needs Assessment for Mental Health Services* [Interim Report], December 1, 1998, p. 8.

- **Inpatient Psychiatric Units in Acute General Hospitals**

An analysis by Commission Staff of HSCRC data shows that, in calendar year 1999, inpatient psychiatry discharges in acute general hospitals represented 7.7% of all discharges – just over 48,000 discharges of a total of 626,187 in that year. Including the 6,691 alcohol or chemical dependency discharges in this calculation brings the percentage of behavioral health-related discharges in 1999 to 8.8% of the total. Table 6 below[22] illustrates shows that between fiscal years 1995 and 2000, inpatient psychiatric service discharges at the acute general hospitals increased slightly, from 22,965 to 23,610 – but in the intervening years, a high of 24,042 in 1996 was followed by the lowest total number of discharges in the six-year period, 23,000 in 1997. During the same period, the average length of an inpatient stay fell from 8.34 days in 1995 to 6.69 days in 2000.

[22] Details of this data by hospital may be found in the Appendices to this paper.

Table 7
Utilization of Inpatient Psychiatric Services
in Acute General Hospitals by Planning Region, 1995-2000

A. Inpatient Psychiatric Discharges						
Planning Region	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Western Maryland	2,562	2,607	2,501	2,727	2,751	2,773
Montgomery County	3,628	3,416	3,303	3,382	3,495	3,597
Southern Maryland	3,441	3,319	3,019	3,371	3,240	3,680
Central Maryland	12,068	13,045	12,747	13,065	13,027	11,981
Eastern Shore	1,266	1,655	1,430	1,238	1,497	1,579
Maryland Total	**22,965**	**24,042**	**23,000**	**23,783**	**24,010**	**23,610**
B. Average Length of Stay						
Planning Region	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Western Maryland	7.01	5.94	5.47	5.58	5.75	6.06
Montgomery County	6.62	6.40	6.23	6.49	6.00	5.53
Southern Maryland	8.35	7.68	6.68	6.63	6.19	5.87
Central Maryland	9.30	7.99	7.66	7.78	7.55	7.59
Eastern Shore	6.86	5.18	5.18	5.91	5.10	5.48
Maryland Average	**8.34**	**7.37**	**6.94**	**7.09**	**6.78**	**6.69**
C. Average Daily Census						
Planning Region	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Western Maryland	49	42	37	42	43	46
Montgomery County	66	60	56	60	57	55
Southern Maryland	79	70	55	61	55	59
Central Maryland	307	285	268	278	269	249
Eastern Shore	24	28	20	20	21	24
Maryland Average	**525**	**485**	**437**	**462**	**446**	**433**
D. Average Charge per Admission						
Hospitals	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Western Maryland	$4,417	$4,263	$4,120	$4,364	$4,471	$4,292
Montgomery County	4,257	4,654	4,594	4,126	4,839	4,354
Southern Maryland	7,115	5,108	4,857	4,378	5,180	5,146
Central Maryland	4,655	6,697	6,569	6,516	6,592	6,594
Eastern Shore	5,012	4,462	4,027	5,115	4,811	4,694
Maryland Average	**$5,937**	**$5,789**	**$5,647**	**$5,841**	**$5,795**	**$5,629**

Source: MHCC Hospital Discharge Abstract Database, and HSCRC financial database

This drop of more than one and one-half days in average length of stay more than offset the increase in discharges, causing the overall average daily census in the psychiatry services of acute general hospitals between 1995 and 2000 to fall from 525 to 433, statewide. The decline in average length of stay was reflected in a decrease in the average charge per admission from $5,937 to $5,629. In each of these measures of the utilization of inpatient psychiatry services at acute general hospitals, there is a slight upturn between 1997 and 1998, but 1999 re-established a trend of decreasing patient days, average length of stay, statewide average daily census, and average charge per admission. Several factors could explain this pattern. One possibility is that 1999 marked the phasing-in of the HSCRC's redesigned hospital rate-setting methodology, the so-called "charge per case" or "CPC" system, and the beginning of a perception that length of

stay had to be further constrained in a medical service in which the course of illness can be less predictable, and less amenable to early discharge and follow-up home health care, than for physical illness or injury.

- **Utilization Trends in the Private Psychiatric Hospitals**

As Table 7 shows, the four private psychiatric hospitals (during part of this period five hospitals were operating) evidenced different utilization trends than the acute general hospitals. Between 1995 and 2000, total discharges dropped to a six-year low of 7.045 in 1997, but by 2000 had climbed back up to 8,812, approaching the 1995 level of 8,947. During the same period, average length of stay increased slowly for the first three years, from 10.89 days in 1995 to 11.68 days in 1997, then climbed more quickly, to 14.59 days in 1998 and 15.34 days in 1999, before falling relatively sharply, back to 11.34 days in 2000.

Table 8
Utilization of Inpatient Psychiatric Services
in Private Psychiatric Hospitals, 1995 – 2000

A. Inpatient Psychiatric Discharges						
Planning Region	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Western Maryland	1,111	1,154	1,158	1,301	1,250	1,150
Montgomery County	1,124	1,081	815	950	948	1,050
Central Maryland	6,712	6,062	5,072	4,811	5,020	6,612
Maryland Total	**8,947**	**8,297**	**7,045**	**7,062**	**7,218**	**8,812**
B. Average Length of Stay						
Planning Region	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Western Maryland	8.09	7.42	7.87	8.68	10.69	7.55
Montgomery County	12.20	10.80	10.88	21.10	22.40	24.60
Central Maryland	11.13	12.03	12.69	14.90	15.17	9.90
Maryland Average	**10.89**	**11.23**	**11.68**	**14.59**	**15.34**	**11.34**
C. Average Daily Census						
Planning Region	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Western Maryland	25	23	25	31	37	24
Montgomery County	38	32	24	55	58	71
Central Maryland	205	200	176	196	209	179
Maryland Average	**267**	**255**	**226**	**282**	**303**	**274**
D. Average Charge per Admission						
Planning Region	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Western Maryland	$5,617	$5,943	$5,333	$6,142	$6,317	$5,285
Montgomery County	13,996	19,633	7,404	15,318	16,100	16,659
Central Maryland	10,201	10,186	8,649	8,271	7,841	8,001
Maryland Average	**$9,850**	**$10,583**	**$7,945**	**$8,836**	**$8,634**	**$8,619**

Source: MHCC Hospital Discharge Abstract Database, and HSCRC financial database

Average daily census climbed correspondingly, in 1999 reaching 303 patients statewide, but even with the next year's marked increase in discharges, the average daily census in the private psychiatric hospitals had dropped in 2000 to 274. Average charge per discharge

fluctuated during this five-year period, reaching a high of $10,583 in 1996, and leveling off in 1999 and 2000 to an average of just over $8,600 among the five institutions.

- **Utilization Trends at the Mental Hygiene Administration Hospitals**

The July 1999 Final Report to the Joint Budget Chairmen submitted by the Mental Hygiene Administration noted that the "average daily population," or "ADP" of State psychiatric facilities was approximately 1,230 patients, in the eight State hospitals. Nearly half of that total are typically adults criminal court-ordered evaluation; their discharge is subject to approval by the courts. Of that figure, as many as 250, roughly one-fifth, are acutely ill, short-stay patients, admitted to beds that will each be used for an average of 16 patients during the course of the year. The needs assessment performed during the first six months of 1999 found that one third of the approximately 450 remaining patients in State hospitals on a given day are medically frail, elderly people whose complex range of physical and psychiatric problems prevent their discharge to nursing homes or other settings. The remaining 300 or so patients have remained in a State psychiatric hospital for a year or longer, and typically have such severe behavioral, social, legal, and medical problems that community placement has not been successful. Recognizing the difficulties ahead in developing a specific, intensive set of services for this core of patients, MHA has told the legislature that it will make their transition to the community a priority over the next five year period.[23] MHA has recognized in advancing this plan, that -- although the average daily population in its facilities has decreased over the last ten years by more than half, from 2,800 to 1,230 – the final JCR report notes that the patients who are left are "the most fragile individuals in the mental health system." The final report concludes that only through developing intensive community-based services for this chronically-ill population can the downsizing of State hospitals continue, given the growth of the State's population, and "a trend toward increasing admissions."

The MHA's interim report to the joint budget chairmen notes that "very few individuals are admitted directly to a State facility." Instead, they come from many sources, including directly from jail or from a court proceeding, and from nursing homes, foster care, or a residential placement; approximately 6% were homeless upon admission, in 1998. Typically, about half of the patients in State hospitals during 1998 were admitted from general hospital emergency rooms or psychiatric units (44% of State patients in 1998) or from private psychiatric hospitals (6% in the same year.)[24] In the State hospital context, stays of up to 30 days are designated as "acute," stays between 31 to 120 days are classified as intermediate, and stays exceeding 120 days are considered long term. In the 1998-1999 period covered by the final report on future downsizing, 14% of State hospital patients were considered acute, 14% were intermediate; patients in these categories move through the system relatively quickly. But 72% -- 972 patients in the survey period – were categorized as long term.

The "trend toward increasing admissions" noted in mid-1999 has continued, and the Mental Hygiene Administration is struggling not only to maintain an ambitious array of community-based treatment options, but also to hold down its hospital census. A recent

[23] *Final Report to the Joint Chairmen: The Statewide Needs Assessment for mental health Services and Mental Hygiene Administration's Five Year Plan for Downsizing and Consolidating of State Psychiatric Hospitals*, July 1999, pp. 6-7.

[24] *Report to the Joint Chairmen on the Statewide Needs Assessment for Mental Health Services* [Interim Report], December 1, 1998, p. 9.

Baltimore *Sun* article described the efforts of officials at Crownsville Hospital Center in Anne Arundel County to move forward with a planned construction project, which would renovate one building and construct another, the first new structure on the campus in nearly 50 years.[25] The plan to build a new central facility at a cost of $44 million, to house 136 beds as well as the hospital's administration, and to renovate an existing 84-bed building nearby, would respond to two stated MHA goals. Not only to the commitment to reduce the acreage and number of buildings dedicated to patient care on the large central Maryland hospital campuses, but it would also save significantly on the upkeep and operation of the outdated, inefficient older buildings currently in use on the Crownsville campus.

The building project is imperative, its superintendent notes in the article, for several reasons. Because State facilities have steadily reduced their beds over the last ten years, and less acutely ill patients can more readily access outpatient treatment and community services, the patients treated at State facilities like Crownsville are "sicker, more violent, and harder to control." The nature of the present physical plant, dispersing patients among various existing buildings, makes responding to emergencies difficult, and can place staff at risk. The continuing high census at Crownsville – its 204 beds are "usually filled," and the facility was only budgeted for 190 beds in the current fiscal year, and 185 for FY 2002 – further exacerbates this situation. The "expectation that the hospital would close more beds" has not simply not materialized, and does not seem likely to happen at any of the State's psychiatric hospitals in the near future. Pressures on levels of reimbursement and lengths of stay at the other two hospital settings have significantly slowed the momentum of the desired downsizing at the State's psychiatric hospitals, and are creating a structural deficit in a system budgeted for fewer patients than it is admitting.

C. Cost and Reimbursement Issues in Providing Inpatient Psychiatric Services

Any comparison of the average charge per admission for inpatient psychiatric services between the different hospitals that provide psychiatric services in Maryland must be understood in the context of the differences in the average length of stay between the acute general hospitals, the private psychiatric hospitals and the state hospitals. Mental Hygiene Administration hospitals and the other hospitals in the state. While cost per patient data was readily available on the Mental Hygiene Administration hospitals, Table 8 below shows the average charge per admission for psychiatric services at the acute general and private psychiatric hospitals for the period 1995 to 1999. During this period, the statewide average charge per admission for psychiatric services declined slightly, from $5,937 to $5,795. On the facility level, in 1999 the average charge per discharge ranged from $3,459 at Memorial Hospital of Cumberland, which does not have a designated psychiatry unit, to $16,100 at the private Potomac Ridge Treatment Center in Rockville.

[25] Jackie Powder, "Crownsville officials seek funds for project," *The Sun*, June 10, 2001, p. 16B.

Table 9
Average Charge per Admission for Inpatient Psychiatric Services at Acute General and Private Psychiatric Hospitals, 1995-1999

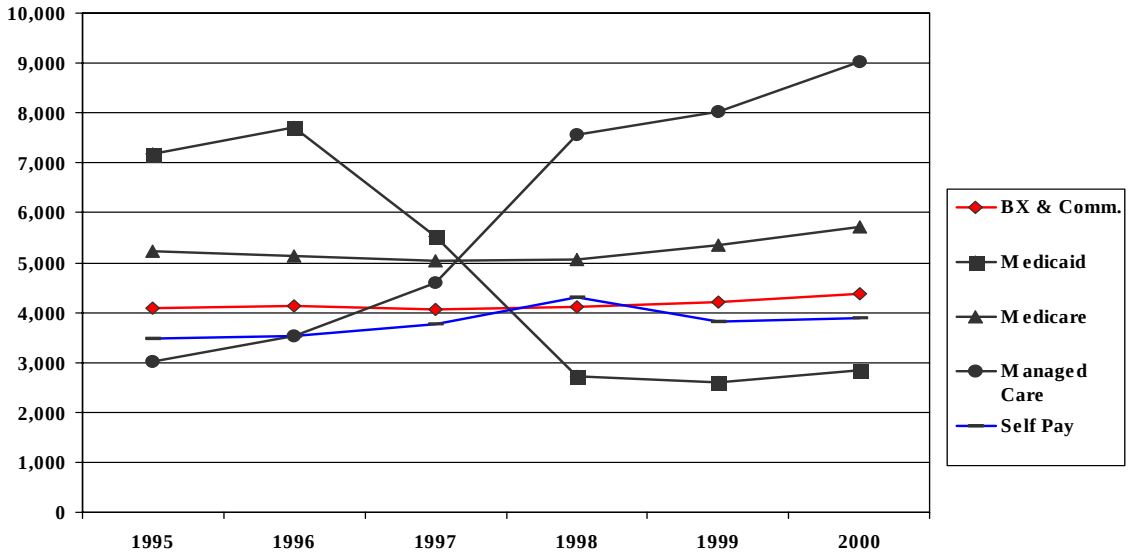
Jurisdiction/ Local Health Planning Area	Hospital	1995	1996	1997	1998	1999
Allegany	Memorial Hospital of Cumberland	$3,089	$2,550	$3,950	$3,863	$3,459
Carroll	Carroll County General Hospital	3,742	3,932	4,599	4,660	5,255
Frederick	Frederick Memorial Hospital	5,148	4,400	4,311	4,886	4,704
Washington	Brooklane Health Services	5,600	5,821	5,404	6,142	7,757
	Washington County Hospital	4,359	4,628	3,687	3,554	3,891
	WESTERN MARYLAND AVERAGE	$4,388	$4,266	$4,390	$4,621	$5,013
Montgomery	Montgomery General Hospital	4,181	4,587	4,708	5,070	4,943
	Potomac Ridge Treatment Center	13,998	19,633	7,404	15,318	16,100
	Suburban Hospital	4,526	5,071	5,185	5,616	5,192
	Washington Adventist Hospital	3,884	4,342	4,013	4,635	4,415
	MONTGOMERY COUNTY AVERAGE	$6,647	$8,408	$5,328	$7,660	$7,663
Calvert	Calvert Memorial Hospital	5,196	4,161	4,735	4,128	4,705
Prince George's	Laurel Regional Hospital	5,249	5,446	4,764	5,088	3,978
	Prince George's Hospital Center	5,551	5,372	4,824	6,314	6,019
	Southern Maryland Hospital Center	3,718	4,792	4,756	5,281	4,895
St. Mary's	St. Mary's Hospital	5,435	5,802	5,527	4,924	5,686
	SOUTHERN MARYLAND AVERAGE	$5,012	$5,108	$4,857	$5,378	$5,180
Anne Arundel	North Arundel Hospital	4,625	5,824	3,934	6,059	4,999
Baltimore County	Franklin Square Hospital	8,056	6,691	6,563	5,916	5,866
	St. Joseph Hospital	5,714	5,940	5,271	7,963	8,458
	Sheppard Pratt Hospital	10,141	9,827	7,876	7,337	7,072
Baltimore City	Bon Secours Hospital	6,253	5,918	5,415	4,093	5,407
	Johns Hopkins Bayview Medical Ctr.	5,367	5,567	6,781	6,951	5,515
	Johns Hopkins Hospital	12,941	11,056	11,005	10,942	9,565
	Maryland General Hospital	5,207	4,973	6,802	5,593	6,040
	Mercy Medical Center	9,224	9,708	6,563	7,876	6,522
	Sinai Hospital of Baltimore	10,117	7,230	4,614	6,055	5,920
	Union Memorial Hospital	6,076	5,038	4,947	4,877	5,566
	University of Maryland	7,011	7,852	6,778	6,591	7,708
Harford	Harford Memorial Hospital	3,922	3,693	3,141	4,186	3,995
Howard	Howard County General Hospital	2,714	2,676	3,293	3,553	3,603
	Taylor Manor Hospital	10,480	11,874	12,407	13,354	11,237
	CENTRAL MARYLAND AVERAGE	$7,190	$6,924	$6,359	$6,756	$6,498
Cecil	Union Hospital of Cecil	3,535	4,043	3,958	5,022	5,865
Dorchester	Dorchester General Hospital	5,058	5,101	3,539	4,510	4,213
Wicomico	Peninsula Regional Medical Center	4,939	4,767	4,760	5,939	4,778
	EASTERN SHORE AVERAGE	$4,655	$4,462	$4,027	$5,115	$4,811
	MARYLAND TOTAL	$5,937	$5,789	$5,647	$5,841	$5,795

- **Reimbursement Issues**

It is with regard to the issues presented by the different sources and rates of reimbursement for inpatient psychiatric services that Maryland's three different hospital settings most influence one another. Each setting of inpatient care faces its own unique set of challenges, but the stresses on one sector clearly affect the utilization and occupancy of the others.

The consensus in the literature about managed behavioral health care, and its influence on mental health services in Maryland and across the nation is that the clearest impact is a reduced length of stay. This is operating in both the acute general and the private hospital sectors in Maryland, but for different reasons. The pressure on State hospital admission and length of stay has increased in response to this restriction on inpatient utilization by managed care. Figure 1 below illustrates the growth in managed care as a payer source for inpatient psychiatric services in one setting, the acute general hospitals. In this figure, all managed care is grouped together, including Medicare and Medicaid; only traditional fee-for-service Medicare and Medicaid is included in lines so labeled. One reason for the dramatic shift between 1997 and 1998, between traditional Medicaid and the "Managed Care" trend line is the institution of the Mental Hygiene Administration's "public mental health system," the so-called "carve-out" of Medical Assistance mental health services from the other medical services grouped under Medicaid HMOs pursuant to Maryland's 1115 Medicaid waiver. Since the other trend lines do not show such significant changes during the same period, there would appear to be significant conversion of Medical Assistance recipients to the carve-out program, shown on the graph as part of the inpatient psychiatric services reimbursed by some form of managed care.

Figure 1
Acute General Hospital Psychiatric Discharges
by Payer, FY 1995-2000



In addition to the general downward pressure on inpatient admission and length of stay exerted by managed care requirements for pre-authorization and rigorous utilization review, each hospital sector is experiencing its own reimbursement stresses. As reported on a continuing basis in newspapers of general circulation and those aimed at the business community, acute general hospitals in Maryland are confronting daunting financial challenges: costs for equipment, blood products and pharmaceuticals, and especially for nurses and other health professionals at a time of critical shortages are escalating while the HSCRC's charge per case rate-setting formula and system-wide agreements are holding down growth in revenue. Some acute general hospitals with psychiatry services are apparently reacting to the perceived pressures on the expected longer lengths of stay by psychiatry patients by aggressively beginning discharge planning as soon as a patient is admitted from the emergency room; often, the only real alternative is to try to arrange placement in the closest State hospital.[26]

Another reimbursement-related crisis that has been well-chronicled in area newspapers has been the struggle of the private psychiatric hospitals, under a system where HSCRC sets rates, but only private insurers are currently obligated to pay those rates. Medicare and Medicaid pay lower rates, and, as noted above, Medicaid payments are mandated by the provisions of TEFRA to be reconciled retrospectively, frequently resulting in private hospitals owing the State money for care provided years before. The plight of Taylor Manor Hospital[27] in Howard County, as it ceased admitting Medicare patients, sought large rate increases from HSCRC, and threatened to close completely, was the most visible and immediate example of the situation faced by the private psychiatric hospitals, who not only dealt with the relatively low levels of payment from the public payers, but – with at least initially more privately insured patients -- are arguably most affected by the strictures of managed behavioral health care. The three bankruptcy filings over the past three years are evidence that the financial crisis facing the private psychiatric hospitals is real and immediate.

In response to the plea of the Association of Maryland Hospitals and Health Systems (MHA) for assistance to its private psychiatric hospital members, and from the recognition that the three sectors are so interrelated that losing one would have a devastating effect on the other two, the Mental Hygiene Administration enlisted HSCRC staff in a DHMH task group (in which MHCC staff also participated) to develop a Prospective Payment System for the State's private hospitals. This system would gradually increase the rates charged at these hospitals, and – after a waiver is obtained from the federal system of retroactive settling up of its current cost-based payments, as well as its restriction on the rates Medicaid may pay in Maryland – require both Medicaid and private insurers to pay these higher rates, contingent on the hospitals' improvements in productivity and cost containment. The General Assembly has endorsed this

[26] Mental Hygiene Administration officials have been meeting with staff from the MHCC and the HSCRC periodically for the past year in an effort to understand and address the problems caused by the perceived reluctance to admit a psychiatric patient with a predictably longer hospital stay. This problem has become most critical for patients who present with an acute episode of mental illness, and who are also developmentally disabled. A work group convened by MHCC staff at the request of MHA and staff from the Developmental Disabilities Administration, assisted by HSCRC staff, is currently examining approaches to encourage hospitals to admit these patients with co-occurring conditions, and to support hospitals in the needed expertise to treat and to find or facilitate their subsequent return to the community.

[27] In March 2001, HSCRC granted Taylor Manor a 19.2% rate increase (M. William Salganik, "19.2% rise OK'd for Taylor Manor," *The Sun*, March 8, 2001), rather than the 29.7% rise it had requested.

approach, including both the increased funding for the system, and language in the FY 2002 budget bill expressing legislative intent that this State-level PPS should be developed and implemented for the freestanding private psychiatric hospitals, by July 1, 2001 if the necessary waiver (referred to as a "State Plan Amendment") has been approved by the Health Care Financing Administration.[28]

The State psychiatric hospitals face the competing pressures of the increase in their admissions beyond budgeted levels, generated in large part by the corresponding restrictions on admissions and length of stay at the acute general and private psychiatric hospitals, and the historic and continuing impetus to reduce the number of beds at State hospitals, if not the number of hospitals themselves. MHA's interim JCR report noted that, if it were not successful in diverting the more chronic, long-term patients to community-based care, the growth in the State's population and the number of patients coming from the other hospital settings would mean that "an additional 200 hospital beds might be needed."[29] That scenario is not what MHA or the General Assembly have envisioned for the State hospital system.

[28] HB 150 (Chapter 102, Acts of 2001). The Bush Administration has just announced that HCFA will now be known as the Centers for Medicare and Medicaid Services, or CMS.

[29] *Report to the Joint Chairmen on the Statewide Needs Assessment for Mental Health Services* [Interim Report], December 1, 1998, p. 8.

III. GOVERNMENT OVERSIGHT OF INPATIENT PSYCHIATRIC SERVICES IN MARYLAND

Government oversight of inpatient psychiatric services in Maryland, including facilities, staff and program operation, is principally the responsibility of four agencies: the Department of Health and Mental Hygiene, the Maryland Insurance Administration, the Health Services Cost Review Commission and the Maryland Health Care Commission (MHCC). Although this report focuses on the oversight responsibilities of the MHCC, it is important to understand how inpatient psychiatric services are regulated by other agencies of state government, particularly when considering a potential alternative to the current framework of Certificate of Need review.

A. Department of Health and Mental Hygiene (DHMH)

The State's Department of Health and Mental Hygiene (DHMH) develops and administers public health programs, for the purpose of protecting and promoting the health of Maryland residents. A highly complex organization with a broad scope of responsibility, DHMH is comprised of over 30 program administrations, 24 local health departments, over 20 residential facilities, and more than 20 health professional boards and commissions. Three administrations within DHMH work closely together in overseeing the operation of and reimbursement for inpatient psychiatric services: the Office of Health Care Quality, Maryland Medical Care Programs, or Medicaid, and the Mental Hygiene Administration.

- **Office of Health Care Quality**

The Office of Health Care Quality (OHCQ) is mandated by State and federal law to determine compliance with the quality of care and life safety standards for a wide variety of health care facilities and related programs, including inpatient psychiatric services in all three settings. OHCQ issues the "special hospital" license to all private psychiatric and State hospitals, and, in the case of acute general hospitals, "deems" them to meet State licensure standards, by virtue of their accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). OHCQ's involvement in general hospitals is generally limited to investigating quality of care complaints from the general public, as well as complaints referred by the State's Insurance Commissioner.

- **Maryland Medical Care Programs (Medicaid)**
- **Mental Hygiene Administration**

The responsibility of the Mental Hygiene Administration for oversight of the inpatient psychiatry services provided in State hospitals was significantly increased in 1997, when it assumed responsibility for Medical Assistance funds for mental health services. In that year, Medicaid mental health care was "carved out" from the remaining array of Medicaid medical (and substance abuse) services, which were restructured pursuant to Maryland's 1115 Medicaid waiver into managed care organizations, or MCOs, collectively known as HealthChoice. The Mental Hygiene Administration assumed responsibility for the combined State and Medical Assistance funding for mental health services to Medicaid recipients, and the resulting Public

Mental Health System ("PMHS") also began to develop programs that included Medicaid recipients ineligible for the waiver MCOs, and also the so-called "gray area" patients ineligible for Medicaid. MHA, in collaboration with the county-level Core Service Agencies, manages the public system, both the inpatient psychiatric segment and an extensive community-based services system. An administrative services organization, Maryland Health Partners, assists MHA in the logistics of managing such functions as eligibility and access services, utilization review, the development of management information systems, claims processing, and system evaluation.

B. Maryland Insurance Administration

The Maryland Insurance Administration (MIA) regulates the practice and the financial performance of both health insurers, third party administrators, and "private review agents," who perform utilization review as well as prior authorization of mental health services for insurers. It establishes requirements both for rate-making and disclosure and for fair trade practices. The MIA also handles consumer complaints regarding coverage decisions and appeals of medical necessity decisions made by HMOs and other health insurers.

The Maryland Insurance Administration assumed responsibility for qualifying and regulating the "private review agents" empowered to act as third-party utilization review entities in managing behavioral health care in the State. This authority had been originally given to the Office of Health Care Quality, and was transferred from the licensing statute (at §19-1301, *et seq*, of the Health-General Article) to become Subtitle 10B,Title 15 of the Insurance Article, Annotated Code of Maryland.[30]

C. Health Services Cost Review Commission (HSCRC)

The Health Services Cost Review Commission is empowered by State law to set the rates that all acute general and private psychiatric hospitals may charge for inpatient psychiatric services. Mental Hygiene Administration hospitals are outside the jurisdiction of the HSCRC. HSCRC initially establishes a hospital's rates through the application of a highly complex and detailed rate review methodology, which uses a peer group evaluation to determine the reasonableness of a hospital's projected expenses. Adjustments are then made to reflect the individual hospital's debt service, uncompensated care, and payer mix. Once a hospital's rates are established, the hospital will usually receive annual increases to its rates for inflation. This system was redesigned during 1999, and now applies the "charge per case" methodology described above, as well as system-wide agreements and adjustments determined by HSCRC action. The historic expertise of HSCRC in developing "home-grown" prospective payment systems has been brought to bear on the development of a payment framework for the State's private psychiatric hospitals, as described in Part III of this paper, which, when fully implemented, represents the most promising means of helping the remaining private hospitals avoid the fate of those closed by bankruptcies in the past three years.

[30] This transfer was effected by Chapters 11 and 112, Acts of 1998.

D. Maryland Health Care Commission (MHCC)

Through the health planning statute, the Maryland Health Care Commission ("MHCC") is responsible for the administration of the State Health Plan, which guides decision making under the Certificate of Need program and the formulation of key health care policies, and the administration of the Certificate of Need program, under which actions by certain health care facilities and services are subject to Commission review and approval.[31] Through the Certificate of Need program, the Commission regulates market entry and exit by the health care facilities and individual medical services covered by CON review requirements, as well as other actions the regulated providers may propose, such as increases in bed or service capacity, capital expenditures, or expansion into new service areas.

"Certificate of Need" as a regulatory tool has three levels, each initiated by a written notice or letter of intent to the Commission. For confirmation that a Certificate of Need is not required to establish a certain kind of health care facility or service, a person requests a "determination of coverage" by CON requirements. Staff and counsel analyze the proposal according to the Commission's statute and applicable regulations, and, if CON review and approval is not needed to undertake the project, the Executive Director issues a determination to that effect as the Commission's designee.

Proposed new health care facilities and specified actions by existing facilities that do require CON approval come to the Commission either in response to a schedule regularly published in the *Maryland Register*, or, if no schedule has been published for a particular service, as an unscheduled review. Procedural rules dictate how unscheduled reviews must be administratively handled so as to permit a comparative review for the new service, if that is appropriate or practical. The CON review itself proceeds according to additional rules set forth at COMAR 10.24.01, evaluates an application against all applicable standards and need projections for the service in the State Health Plan, and applies six general review criteria related to the need for and the likely impact of the proposed project on the health care system. Statute requires that staff (or a Commissioner appointed as a reviewer in a comparative or competitive review) bring a recommendation on a proposed project to the full Commission within 90 days of docketing.[32] The first thirty days after docketing are set aside as a public comment period, in which interested members of the public, as well as "interested parties" in the legal sense, may

[31]The MHCC also establishes a comprehensive standard health benefit plan for small employers, and evaluates proposed mandated benefits for inclusion in the standard health benefit plan. In its annual evaluation of the small group market, the Commission considers the impact of any proposed new benefits on the mandated affordability cap of the small group market's benefit package, which is 12 percent of Maryland's average wage, and the impact of any premium increases on the small employers. With regard to nursing-home level care, Maryland's Comprehensive Standard Health Benefit Plan for Small Businesses currently includes a "skilled nursing facility care" benefit characterized as "100 days as an alternative to otherwise covered care in a hospital or other related institution, i.e. nursing home," which carries "a $20.00 co-payment or applicable coinsurance, whichever is greater."

[32] Docketing is the formal start of a CON review; the time period in which a recommendation is to come to the full Commission is 150 days, if an evidentiary hearing is held. However, 1995 legislation to streamline the CON review process mandated the adoption of regulations that restrict evidentiary hearing to those cases in which the "magnitude of the impact" of a potential new facility or service merit the additional time and transactional cost.

comment on the proposal or, if they meet criteria in regulation, enter the review in opposition to the project.

Since 1985, health planning statute has permitted the Commission to find, "in its sole discretion," that certain actions by existing health care facilities -- if the facilities proposing them are merging, or have merged and are proposing to further consolidate or to reconfigure their bed capacity or services – may be exempted from the Certificate of Need requirement that would otherwise apply. This so-called "exemption" from the CON requirement may be granted through action by the Commission for several kinds of actions proposed "pursuant to a consolidation or merger" of two or more health care facilities, if the proposed action:

- Is "not inconsistent with" the State Health Plan[33];
- "Will result in the delivery of more efficient and effective health care services"; and
- Is "in the public interest."[34]

A merged asset system seeking such a finding by the Commission must provide notice of its intent at least 45 days before it requests action on the proposal. Additional procedural regulations (at COMAR 10.24.01.04C) require the Commission to provide notice to the public, with the opportunity to comment on the proposed action.

Market Entry

Entry into the market for proposed new inpatient psychiatry facilities or bed capacity has been explicitly regulated through Certificate of Need since the 1988 enactment of a list of "medical services" subject to CON if established by an otherwise-regulated health care facility.[35] As with all Certificate of Need review in Maryland, the analysis of applications for CON approval for new facilities or expanded bed capacity[36] in either of these two "special hospital" services evaluates how proposed projects meet the applicable standards and policies in the State Health Plan, and how they address the six general review criteria found in the Certificate of Need procedural regulations at COMAR 10.24.01.07.[37] The State Health Plan currently in effect requires that a facility obtain a separate Certificate of Need for each division of inpatient psychiatry recognized by the Plan, i.e., a designated child, adolescent, or adult psychiatric service.

[33] "Or the institution-specific plan developed and adopted by the Commission," pursuant to its authority at Health-General Article §19-122, Annotated Code of Maryland.
[34] Health-General §19-123(j)(2)(iv).
[35] Health-General §19-123 (a).
[36] Bed increases in either service may be authorized by the Commission without CON review through the statutory "waiver bed" rule that permits increases of 10 beds or 10% of total beds, whichever is less, two years after the last change in licensed capacity.
[37] In brief, these criteria require an application to: (1) address the State Health Plan standards applicable to the proposed project; (2) demonstrate need for the proposed new facility or service; (3) demonstrate that the project represents the most cost-effective alternative for meeting the identified need; (4) demonstrate the viability of the project by documenting both financial and non-financial resources sufficient to initiate and sustain the service; (5) demonstrate the applicant's compliance with the terms and conditions of any previous CONs; and (6) "provide information and analysis" on the "impact of the proposed project on existing health care providers in the service area."

The State Health Plan rules and standards that are applied to CON reviews of proposed new facilities or expansions fall into several distinct categories, including:

- **docketing standards**, which determine whether applications for new facilities or expansions will be accepted and may be docketed for review;
- **review standards**, which are applied to all applications, and provide a composite description of what the Commission has established -- through its staff research, deliberation, and the public adoption process – should characterize a facility or service of the kind under review;
- **approval rules**, which set threshold standards that must be met, or a proposed project may not be recommended for Commission approval; and
- **modification rules,** which guide the review of certain kinds of changes proposed to projects already granted Certificate of Need approval.

The method of projecting future need for inpatient psychiatric services under the Plan currently in effect is regional in its focus, based on the five historic health planning areas: western Maryland (which since 1987 has included Carroll County, by the designation of the county's government), Montgomery County, central Maryland (Baltimore City and the Baltimore metropolitan counties, minus Carroll), southern Maryland (including prince George's County), and the Eastern Shore. This regional rather than jurisdictional basis for bed need projection distinguishes inpatient psychiatry in acute general hospitals from the other medical services provided in this hospital setting.[38]

Market Exit

As noted in the discussion in Part II concerning the effect of HB 994 and its changes to Certificate of Need law applicable to "the closure of a hospital or part of a hospital," two of these 1999 statutory provisions significantly altered the Commission's oversight authority with regard to potential closures of hospitals or their inpatient psychiatry services, and with regard to the bed capacity of individual medical services.

The Certificate of Need procedural rules applicable to hospitals in jurisdictions with three or more hospitals at §19-123 (l) explicitly include State hospitals, which also may close without action by the Commission, provided that the Commission has received written notification 45 days before the planned closure, and the hospital (or in this case, the Department, specifically MHA) has held a public informational hearing in the area affected by the closure.

Far less clear is whether this comparatively quick and easy closure process also applies to the private psychiatric hospitals, which are not classified as general hospitals under the licensure

[38] With the scheduled June 21, 2001 release for public comment of a new Plan chapter for Acute Inpatient Obstetric Services, COMAR 10.24.12 (prior to its formal proposal as permanent regulations), obstetrics will become the second acute hospital service not subject to a jurisdictional need projection threshold. The development of this new Plan section follows the Commission's recommendation to the General Assembly, conveyed in the Phase 1 Final report in the legislatively-mandated study of Maryland's CON program.

statute.[39] Interpretations of the provisions of HB 994 related to acute general hospitals are based on their interconnectedness: the bill ended the creation of waiver, or "creep" beds in general hospitals (this was clarified in the Commission's implementing regulations), in favor of the annual recalculation of licensed bed capacity "for a hospital classified as a general hospital,"[40] according to a factor of 140% of its previous year's average daily census. HB 994 has not been interpreted as precluding the authorization of waiver beds for private psychiatric hospitals, and it has not been interpreted as permitting any but acute general hospitals (i.e., those subject to the annual application of 140% of last year's average daily census) to increase or decrease beds between members of merged asset systems.

The significance of this set of statutory interpretations is that, if the increased ease of hospital closures does apply to the special-licensed private psychiatric hospitals, all but one of them (Brooklane in Washington County) are located in the large, populous jurisdictions where the closure of a hospital is simply a matter of a 45-day notice and a public informational hearing. The Commission would, in this interpretation of the 1999 statutory changes regarding hospital closures, have no authority over the decision to close two of the four remaining private psychiatric hospitals. If that worst of worst case scenarios were to come about, the acute general hospitals and the State psychiatric facilities – subject to their own financial and clinical stresses, as discussed in Section III – would be extremely hard pressed to compensate for the loss of that bed capacity.

[39] §19-307(a), Health-General Article.
[40] §19-307.2(a), Health-General Article.

IV. MARYLAND REGULATION OF INPATIENT PSYCHIATRIC SERVICES COMPARED TO OTHER STATES

As illustrated in Figure 2 on the next page, Maryland is one of 36 states, plus the District of Columbia, that maintains a Certificate of Need program for some number of new or expanded health care facilities and services. Maryland ranks in the lower third of what the American Health Planning Association ("AHPA"), on whose annual survey of all CON programs the following figure is based, calls its "Relative Scope and Reviewability" listing, which lists the state CON programs in descending order, based such factors as the number of services regulated, and the dollar level of capital and service review thresholds.

Commission Staff once again accessed the AHPA's internet forum of state CON and other major health regulatory programs, to determine which of the 37 programs include inpatient psychiatry facilities and bed capacity in the scope of their respective Certificate of Need review. AHPA's listing shows that 11 of the 37 programs regulate inpatient psychiatric services through CON review. Ten of the eleven programs responded to Staff's electronic inquiry.

The state of Florida regulates through CON review "the establishment of new hospital inpatient general psychiatric services, the construction or addition of new hospital inpatient general psychiatric beds, the conversion of licensed hospital beds to hospital inpatient general psychiatric beds, and specifies which services can be provided by licensed or approved providers of hospital inpatient general psychiatric services."[41]

North Carolina regulates the addition of inpatient psychiatric beds through CON, and projects future bed need in 39 mental health planning regions. Kentucky, by contrast, applies a minimum occupancy threshold as well as a bed-to-population ratio in determining the need for any proposed new capacity. Virginia also applies an occupancy threshold – 85% -- and reviews any increase in licensed bed capacity, regardless of cost; however, Virginia's capital threshold for the CON review of proposed renovations of existing facilities is considerably higher than Maryland's $1.45 million, at $5 million. Virginia specifically excludes State psychiatric facilities from CON review.[42]

Oregon only covers inpatient psychiatry services "if provision of this service involves the creation of a new hospital, or a change in the category of license for an already operating hospital, if the hospital proposes to offer a service not already within its existing license." South Carolina regulates inpatient psychiatry services through its State Health Plan and CON review, as does Alaska, whose CON program is about to undertake the review of a 60-bed child and adolescent inpatient facility.[43]

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[41] Electronic mail communication from Jeffrey Gregg, Chief, Bureau of Health Facility Regulation, Florida Agency for Health Care Administration, and Florida Rules for Certificate of Need and Financial Analysis, at 59C-1.040, *et seq*.

[42] Electronic mail communications from Lee Hoffman, North Carolina CON program; Jayne Arnold, Kentucky CON program; and Dean Montgomery, director of the Health Systems Agency of Northern Virginia.

[43] Electronic mail communications from Jana Fussell, Oregon CON program; Albert Whiteside, South Carlina CON program; and David Pierce, Alaska CON program.

Vermont's Certificate of Need guidelines include policies and standards for the review of proposed inpatient psychiatric services in "local general hospitals," and therapeutic community residences with "primarily health-related" services. In Illinois, a Certificate of Need is required to establish a new psychiatric hospital, or to add beds to an existing facility. The program in Illinois has authority over not only what it calls "acute mental illness" beds and services, but also over services for the chronic mentally ill – "specialized long term care services" – as well as for those with co-occurring developmental disabilities.

Missouri's CON program exercises jurisdiction over "inpatient acute or long term care in hospitals to emotionally disturbed patients." For a proposal involving new inpatient psychiatric capacity in Missouri to require full Certificate of Need review, "the proposed cost must exceed one of our expenditure minimums (either $1 million capital expenditure or $1 million in medical equipment.) Missouri does not have jurisdiction over state-owned and operated psychiatric facilities.[44]

[44] Electronic communications from Stan Lane, Vermont CON program, and Don Jones, Illinois Department of Public Health, Division of Facilities Development. Letter dated May 24, 2001 to Susan Panek from Michael Henry, for Thomas R. Piper, Director of the Missouri CON program.

Figure 2

COMPARISON OF NUMBER AND SCOPE OF HEALTH CARE FACILITIES & SERVICES COVERED IN STATES WITH CON PROGRAMS

RANK[45]	STATE[46]	Acute Care	Air Ambulance	Amb Surg Ctrs	Burn Care	Business Cmptrs	Cardiac Cath.	CT Scanners	Gamma Knives	Home Health	ICF/MR	Lithotripsy	Long Term Care	Med Off Bldg	Mobile HiTech	MRI Scans	Neo-ntl Int Care	Obstetric Svcs	Open Heart Svcs	Organ Transplant	PET Scans	Psychiatric Svcs	Rad Therapy	Rehab	Renal Dialysis	Res Care Fac	Subacute	Substance Abuse	Swing Beds	Ultrasound	Capital Threshold	Other Services[47]
31.2	ME	X	X	X	X		X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X			X	X	X	X	
30.8	WV	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X
27.6	GA	X		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X				X			X	X
27.5	CT	X	X	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X				X	X	X	X	X
27.0	AK	X	X	X	X		X	X	X	X		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
22.5	VT	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X			X	X		X	
21.0	MO	X		X			X		X		X	X	X		X	X	X	X	X		X	X	X	X	X	X	X	X			X	X
20.9	SC	X		X			X		X	X	X	X	X		X	X	X	X	X		X	X	X	X			X	X			X	
19.8	MS	X		X			X		X	X	X	X	X			X			X		X	X	X	X	X	X			X	X		X	
18.4	NC	X	X	X	X		X	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X			X			X	X
18.4	IL	X		X	X		X		X		X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X		X	X
17.1	NJ	X			X		X		X	X	X	X	X		X		X	X	X	X	X	X	X	X		X		X			X	
16.2	KY	X		X			X			X	X		X		X	X	X		X	X		X	X	X		X	X	X			X	X
16.1	DC	X		X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X			X	X	X		X	
15.3	**MD**	**X**		**X**	**X**		**X**			**X**	**X**		**X**				**X**	**X**	**X**	**X**		**X**		**X**				**X**	**X**	**X**		**X**	**X**
15.2	MI	X	X	X			X	X	X			X	X		X	X	X		X	X	X	X	X		X				X		X	X
15.2	RI	X		X			X	X	X				X		X	X	X	X	X	X	X	X	X	X			X	X	X		X	
15.0	HI	X	X	X	X		X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X	X		X	
13.6	TN	X		X			X	X		X	X	X	X			X	X				X	X	X	X			X	X			X	X
13.2	NY	X		X	X		X	X	X	X	X	X	X		X	X	X		X	X		X	X	X	X			X	X	X	X	
12.6	WA	X		X	X					X			X				X	X	X	X				X	X		X		X		X	X
12.0	AL	X		X			X		X	X		X	X			X	X	X	X	X	X	X	X	X	X			X	X		X	X
11.7	NH	X		X			X	X				X	X		X	X			X			X	X	X				X			X	
8.4	AR									X	X		X													X	X		X		X	X
8.4	FL	X			X					X	X		X				X		X	X		X				X	X	X				X
8.1	IA			X			X				X		X						X	X	X		X								X	X
8.0	VA	X		X			X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X				X			X	X
7.0	OK										X		X									X						X			X	X
6.3	MT			X						X	X		X											X				X	X		X	
5.1	MA		X	X					X			X	X			X	X		X	X	X	X	X	X		X		X		X	X	X
4.9	NV	X		X							X		X											X			X	X			X	
4.8	DE	X		X			X					X	X								X		X								X	X
4.4	WI										X		X														X				X	X
1.0	OH												X																		X	X
0.6	OR												X																X		**	
0.6	NE												X											X							**	
0.4	LA										X		X																			

This chart is adapted from the American Health Planning Association's annual graphic, last updated in AHPA's 2000 Directory of Health Planning Policy & Regulatory Agencies (11th ed.), which compares the "National Relative Scope and Reviewability Threshold of CON Regulated Services" among the states. The 2000 version of AHPA's graphic contained some errors with regard to Maryland's services, which have been corrected in Staff's adaptation. Consequently, the "severity" index as calculated according to several factors, including number of services regulated and level of capital review threshold, may not precisely reflect Maryland's "weight" or "severity" according to AHPA's formula, compared to other CON states. However, the chart's relative position of Maryland's CON program--which does not cover a significant number of health care facilities and services regulated by many other states--would still be in the middle range of CON programs, nationwide. ** Any capital expenditure for LTC

[45] No. of services x weight as determined by the Missouri CON Program.
[46] Including the District of Columbia.
[47] Services in addition to those most often CON-regulated.

V. ALTERNATIVE REGULATORY STRATEGIES: AN EXAMINATION OF CERTIFICATE OF NEED POLICY OPTIONS

The options discussed in this section represent alternative regulatory strategies to achieve the policies, goals and objectives embodied in Maryland's Certificate of Need program. The role of government in these options describes a continuum varying from the current role (Option 1), to a more expanded role on one end of the continuum (Option 2), to essentially no role, at the other end of the range of options (Option 6). The options below, singly or in combination, suggest potential alternative strategies that could be considered in the context of the larger issue of the regulation of health care services in Maryland. This is not an exhaustive list of options. The Commission expects other options and ideas to be generated through the public comment process. The questions suggested in the guiding principles in the Commission's *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Study Overview*, provide a framework for the evaluation of these options.

A. Option 1 – Maintain Existing Certificate of Need Program Regulation

This option would maintain the Certificate of Need program as it currently applies to inpatient psychiatric services. Under current law, establishing a new inpatient psychiatric service – or a new division of service designation, among child, adolescent, or adult -- requires a Certificate of Need, based on Commission review of an applicant's consistency with the State Health Plan policies, standards need projections, and other review criteria. As previously noted, a merged asset multi-hospital system may reconfigure its psychiatric service by relocating beds from one member hospital with a psychiatric service to another member hospital that may not have an inpatient psychiatric service with notification to the Commission, provided that the hospitals are in the same jurisdiction.

Reconfiguring a system's service capacity between facilities across county lines, on the other hand, may not be accomplished through a written notice, but requires that the Commission grant an exemption from Certificate of Need review. Since 1985, the Commission has had statutory authority to approve such exemptions to change the "type or scope of any health care service" offered by a health care facility (or facilities) that are part of a merged asset system, if the Commission finds, "in its sole discretion," that the proposed reconfiguration of beds or services is "not inconsistent with the State Health Plan," will result in the more efficient and effective delivery of health care services, and is in the public interest."[48] Psychiatric beds may be relocated across jurisdictions because the State Health Plan projects need for inpatient psychiatric services by region, as noted above. As will be discussed under Option 2, Certificate of Need approval is not required to close an inpatient psychiatry service in an acute general hospital; depending on the number of hospitals in the jurisdiction, this may be accomplished by either a 45-day written notice, or an exemption from CON review by the Commission.

This option continues to promote the General Assembly's incentives for hospital mergers by allowing merged asset systems the flexibility to reconfigure services, under certain circumstances, without the requirement to obtain a CON. Regarding service closures and the stricter exemption process for closures in one- and two-hospital jurisdictions than for multi-hospital jurisdictions, this option also assumes that the benefits of closing a service in multiple-hospital jurisdictions outweigh the costs of reduced access in areas of possible excess capacity.

[48] At Health-General Article §19-123(j)(2)(iv), Annotated Code of Maryland.

A fundamental assumption of continuing to require CON review and approval to establish a new inpatient psychiatric service or freestanding hospital facility assumes that the cost of establishing a new service -- and particularly the cost of building a new facility -- may outweigh the benefits to increased access. Although managed care has reduced the potential for over utilization, competition among hospitals for managed care contracts is an aspect of the market that may have the opposite effect by providing an incentive to add new programs. CON can, therefore, help to ensure a rational, planned growth in capacity in the system.

B. Option 2 – Expand Certificate of Need Program Regulation

Under current health planning law, the closure of an inpatient psychiatric service requires either a 45-day notice or an exemption from CON review, depending upon the number of hospitals in the jurisdiction. The closure of a State hospital or part of a State hospital requires only the 45-day notification, regardless of the jurisdiction. Restoring the statutory requirement for some level of action by the Commission in all proposed closures of inpatient psychiatric services in acute general hospitals is a second alternative regulatory strategy. A finding by the Commission that exempts a proposed hospital service closure from CON review is currently needed in jurisdictions with one or two hospitals; only notice to the Commission and a public hearing is necessary for a service closure in a multiple hospital jurisdiction. Option 2 would strengthen current oversight of inpatient psychiatric service closures by requiring hospitals in multiple hospital jurisdictions to obtain an exemption to exit the market.

This option supports placing more public policy emphasis on ensuring geographic access to inpatient psychiatric services, particularly for vulnerable populations. Although the more recent hospital closures in Baltimore (Liberty Medical Center and Church Hospital) did involve the closure of some psychiatric services, the potential impact of future hospital closures on access for some of the city's most vulnerable residents, those with fewer transportation options or support services, must be considered. The current CON rules allow hospitals in multiple hospital jurisdictions, including Baltimore City, to close without Commission oversight or action. Requiring the same level of review for multiple hospital jurisdictions as now exists in one- or two-hospital jurisdictions would allow public review and community input into the potential impacts and solutions of the closure of an inpatient psychiatry service in all the areas of the state. On the other hand, it must be noted that this option modifies previous efforts at CON liberalization by reimposing some level of review (i.e., exemption) that has been eliminated from statute for hospitals in the most populous Maryland jurisdictions.

C. Option 3 – Deregulate Creation of Additional Levels of Inpatient Psychiatric Services from Certificate of Need Review

The current State Health Plan governing the review of inpatient psychiatric services requires a separate Certificate of Need review and approval for each of the three divisions of inpatient psychiatric bed capacity: child, adolescent, and adult. This option would remove the requirement for a separate Certificate of need review and approval for an additional division or divisions of care, if the facility seeking to expand its service capabilities already operates one of designated psychiatric services.

The procedural means of obtaining the additional service division or divisions could either involve an exemption from Certificate of Need review, which would require an expedited 45-day Staff review and a recommendation to the Commission that the proposed addition is "not

inconsistent with the State Health Plan," would result in the more efficient and effective delivery of health care services, and would be in the public interest. Alternatively, the addition of another division of designated inpatient psychiatric bed could be accomplished through a determination of non-coverage by Certificate of Need review.

The key factor in a Staff analysis -- under either level of review procedure in this option -- would be the commitment of the hospital proposing to add one or more service divisions to an operating inpatient psychiatry facility or unit to meet the existing State Health Plan requirements for the separate service designations. Perhaps the most important of these is the requirement that a facility operating units for children, adolescents, and adults on the same site "must provide that physical separations and clinical/programmatic distinctions are made between different patient groups."[49] A requirement could be considered for inclusion in the Plan's standards to be applied in a Staff analysis of a proposed new division of psychiatric service, that the program employ a Board-certified specialist in the area being added. This option assumes that an existing provider presents certain advantages, of available expertise and experience, of quality assurance and outpatient services already in place. Making the addition of other service divisions easier administratively – provided that the minimum quality and qualifications were present – could potentially prove enough of an incentive for hospitals with existing psychiatry services that more child and adolescent beds might come into the system. This would address an access issue raised in Section II of this paper.

D. Option 4 -- Deregulate Inpatient Psychiatric Services from Certificate of Need Review; Create Data Reporting Model to Encourage Quality of Care

Another option for inpatient psychiatric service regulation involves replacing the CON program's requirements governing market entry and exit with a program of mandatory data collection and reporting, to encourage continuous quality improvement through the gathering and periodic publication of comparative information about existing programs. Option 4 supports the role of government to provide information in order to promote quality health services. Performance reports, or "report cards" as they have come to be called, are intended to incorporate information about quality into decisions made by both employers and employees in their choice of health plans, and by consumers whose health plans permit a measure of choice in providers. Performance reports can also serve as benchmarks against which providers can measure themselves, and seek to improve quality in any areas found deficient. As such, report cards may both inform consumer choice and improve the performance of health services. Report cards for inpatient psychiatric services – as for any other health care service -- could be implemented in at least two ways: public report cards designed for consumers, or performance reports designed to provide outcomes information and best-practice models for providers.

- ***4A - Public Report Card for Consumers Specific For Inpatient Psychiatric Services***

This option would create a vehicle for public reporting of basic service-specific information in a report card style format, promoting consumer education and choice. Behavioral health service report cards could be designed to report on facilities, physicians or provider groups, or a combination. In response to a 1999 legislative mandate, the Commission is proceeding with the development and implementation of hospital and ambulatory surgery facility report cards, similar to the HMO report cards it currently produces. Therefore, this option for inpatient psychiatric services could be considered a component of the planning for acute general

[49] COMAR 10.24.07, Policy 4, page AP-4.

hospital report cards, perhaps as the subject of a future supplementary report, and could eventually be extended to the private psychiatric hospitals, and potentially even to State hospitals.

- ***4B - Provider Feedback Performance Reports***

Under this option the Commission, or another public or contracted private agency, would establish a data collection and feedback system designed for use by providers. Like the report card option, this involves mandatory collection of detailed outcomes and process information from all hospital inpatient services to measure and monitor the quality of care using a selected set of quality measures specific to inpatient psychiatric services. This option is consistent with the recent national policy debate regarding the need for more information and improved accountability for outcomes. While CON typically serves as a means to create and allocate new facility-based medical service capacity on a rational, planned basis and is not generally intended to monitor quality after an approved program begins operation, this option does further that objective.

E. Option 5 -- Deregulate Mental Hygiene Administration Hospitals From Certificate of Need Review

The State hospitals run by the Mental Hygiene Administration historically treat a different population from the psychiatric units in the acute general hospitals and the private psychiatric hospitals. Although efforts have been made in the past to consolidate and possibly close some of the state hospitals, demand for services at the state facilities remains high, and in recent years it has actually increased. Given the unique nature and target population of the State-run psychiatric hospitals, and the control exercised on operating capacity by budgetary constraints, Certificate of Need may not be needed, as an additional means of controlling the cost, access or quality of those institutions.

Under this option, all CON review requirements related to both market entry and exit would be eliminated with regard to State psychiatric hospitals. The Department of Health and Mental Hygiene, through the Mental Hygiene Administration, would allocate inpatient psychiatric services, and determining where new services may be needed, and where services would be closed, without the need for a review or action by the Commission. As noted in the discussion of Certificate of Need oversight of inpatient psychiatric services in other states, State-operated facilities are often "carved out" of the CON review process, and these decisions are made a matter of public health planning and budgetary priorities. In proposing this option for consideration, Commission Staff recognizes that the inter-connected nature of the hospital settings in which inpatient psychiatric services are provided in Maryland would still require its close cooperation with the Mental Hygiene Administration, in understanding the behavior of the entire system.

F. Option 6 – Deregulation of Inpatient Psychiatric Services From Certificate of Need Review

Although seldom disputed as an effective way to promote geographic access to care, the efficacy of Certificate of Need as a regulatory tool to control cost or address quality of care has been questioned by advocates for a totally market-driven, entrepreneurial approach to establishing and providing health care services. In Maryland, it can be argued that quality of care, once a CON-approved facility or service begins operating, is addressed by the standards of

JCAHO and the Office of Health Care Quality. It could be argued that HSCRC effectively controls hospital costs at the acute general and private psychiatric hospitals, and that the State budget and now the utilization controls of the Public Mental Health System act to constrain costs in the public sector.

Although concerns over the links between volume and outcomes, and over the impact unconstrained growth in the market would have on an already critical shortage of nurses and other key health personnel have produced the interesting view in some quarters that CON's original purpose seems to have developed new relevance, under this sixth option, all CON review requirements related to both market entry and exit would be eliminated for inpatient psychiatric services in Maryland.

Repeal of CON has been associated with increases in supply in several states. The complex of reimbursement issues and length of stay constraints affecting this particular medical service – discussed in some detail in this Working Paper – may well mean that this increased supply would be less likely in inpatient psychiatry. A bigger concern at the present time may be the number of hospitals considering discontinuing their inpatient psychiatry service, rather than those who would add the service if CON review were not required.

If the factors leading some facilities to reconsider their existing psychiatry services were to be addressed, the effect of duplicating programs that require professional staff already in short supply, and that need to be available 24 hours per day, would add direct staffing costs and indirect overhead to the system. If competition for staff increases, staffing costs could rise still higher. The question raised by this option, proposed in all of the Working Papers to date, and to be included in the remainder still to come, is whether the cost efficiencies to be achieved through competition would offset the cost pressures generated by competition, in the long run.

V. SUMMARY

Psychiatry services are among the medical services defined in health planning statute that requires a CON to establish and, in some cases, to expand in a hospital. This report examines the current policy and regulatory issues affecting inpatient psychiatric services, and outlines several alternative policy options for changes to CON regulation, and the potential implications of those changes. Table 9 summarizes the policy options discussed in this paper. It is the expectation of the Commission that the public comment process involved in evaluating the CON program will identify additional policy options and approaches that merit consideration. The Commission remains particularly interested in receiving comments on techniques for quantifying the financial impact of changes in CON regulation.

Table 9
Summary of Regulatory Options

Options	Level of Government Oversight	Description	Administrative Tool
Option 1 Maintain Existing CON Regulation	No Change in Government Oversight	- Market Entry Regulated by CON - Market Exit Through Notice or Exemption	Commission Decision (Certificate of Need/Exemption/ Notice)
Option 2 Expanded CON Regulation	Increase Government Oversight	- Market Entry Regulated by CON - Market Exit Through Exemption in all cases	Commission Decision (Certificate of Need/Exemption)
Option 3 Deregulate Creation of Additional Divisions of Inpatient Psychiatric Services from Certificate of Need Review	Change government Oversight	- Initial Market Entry Regulated by CON (and Exemption, for merged systems); additional divisions by exemption; - Market Exit Through Notice or Exemption	Commission Decision (Certificate of Need/Exemption/ Notice)
Option 4 Deregulate Inpatient Psychiatric Services from CON Review; Create Data Reporting Model	Reduce Government Oversight	- No Barrier to Market Entry or Exit	Performance Reports/Report Cards
Option 5 Deregulate Mental Hygiene Administration Hospitals from CON Review	Change Government Oversight	- No Barrier to Market Entry for State Hospitals	Notice letter to Commission from DHMH
Option 6 Deregulate Inpatient Psychiatric Services from CON Review	Change Government Oversight	- No Barrier to Market Entry or Exit	Remaining agencies exercise oversight authority (OHCQ, MHA, Medicaid)

Appendices

Appendix A
Trends in Acute General and Private Hospitals Patient Days, Inpatient Psychiatric Services
1995 to 2000

Jurisdiction/ Local Health Planning Area	Hospitals	1995	1996	1997	1998	1999	2000
Allegany	Memorial Hospital of Cumberland*	105	113	143	53	78	56
	Sacred Heart Hospital	4,731	4,035	3,176	4,408	4,365	4,075
	Total	4,836	4,148	3,319	4,461	4,443	4,131
Carroll	Carroll County General Hospital	5,738	4,449	4,322	4,738	5,409	5,734
Frederick	Frederick Memorial Hospital	3,725	2,769	2,800	3,294	3,296	3,549
Garrett	Garrett County Memorial Hospital*	68	59	46	18	47	36
Washington	Brooklane Health Services	8,992	8,565	9,110	11,293	13,357	8,680
	Washington County Hospital	3,602	4,053	3,199	2,716	2,623	3,451
	Total	12,594	12,618	12,309	14,009	15,980	12,131
	WESTERN MARYLAND TOTAL	26,961	24,043	22,796	26,520	29,175	25,581
Montgomery	Holy Cross Hospital*	2,163	1,266	984	1,272	576	184
	Montgomery General Hospital	6,713	5,683	5,362	5,947	5,656	5,965
	Potomac Ridge Treatment Center	13,712	11,675	8,866	36,576	21,233	25,830
	Shady Grove Adventist Hospital*	94	44	55	144	162	170
	Suburban Hospital	5,114	5,096	4,155	4,312	4,799	5,028
	Washington Adventist Hospital	9,920	9,763	10,022	10,270	9,768	8,901
	MONTGOMERY COUNTY TOTAL	37,716	33,527	29,444	58,521	42,194	46,078
Calvert	Calvert Memorial Hospital	4,147	3,095	2,611	2,574	2,375	2,813
Charles	Civista Medical Center*	57	18	23	65	35	18
Prince George's	Doctors Community Hospital*	41	51	33	54	32	32
	Fort Washington Medical Center*	4	-	9	-	10	9
	Laurel Regional Hospital	4,676	4,913	3,705	3,691	2,434	3,391
	Prince George's Hospital Center	10,151	8,639	5,984	7,878	7,623	7,739
	Southern Maryland Hospital Center	6,432	5,743	5,266	6,010	5,379	5,708
	Total	21,304	19,346	14,997	17,633	15,478	19,710
St. Mary's	St. Mary's Hospital	3,221	3,023	2,542	2,092	2,166	1,950
	SOUTHERN MARYLAND TOTAL	28,729	25,482	20,173	22,364	20,054	24,491
Anne Arundel	Anne Arundel Medical Center*	83	91	52	79	85	92
	North Arundel Hospital	3,891	4,092	4,158	3,685	3,476	3,442
	Total	3,974	4,183	4,210	3,764	3,561	3,534
Baltimore County	Northwest Hospital Center*	92	143	112	58	89	62
	Franklin Square Hospital	8,237	7,115	8,117	8,305	5,670	5,891
	Greater Baltimore Medical Center*	149	170	122	203	190	326
	St. Joseph Hospital	4,117	3,059	5,224	5,679	5,943	6,127
	Sheppard Pratt Hospital	51,254	51,715	46,399	53,985	59,083	50,182
	Total	63,849	62,202	59,974	68,230	70,975	62,588

Jurisdiction/ Local Health Planning Area	Hospitals	1995	1996	1997	1998	1999	2000
Baltimore City	Bon Secours Hospital	83	61	69	27	2,667	2,224
	Childrens Hospital*	-	-	-	2	-	-
	Church Hospital	36	70	28	51	32	-
	Good Samaritan Hospital*	101	93	161	114	61	326
	Harbor Hospital*	92	44	48	48	41	64
	Johns Hopkins Bayview Medical Ctr.	5,620	5,440	5,509	5,504	4,416	5,161
	Johns Hopkins Hospital	28,943	27,253	26,134	26,445	27,410	28,069
	Kernan Hospital*	1	-	7	-	-	-
	Liberty Medical Center*	15,248	13,800	10,886	12,549	6,591	-
	Maryland General Hospital	7,223	6,728	5,788	6,134	6,803	6,996
	Mercy Medical Center	1,691	1,692	801	415	93	72
	Sinai Hospital of Baltimore	6,665	6,078	6,341	6,905	7,320	7,546
	St. Agnes Hospital*	179	167	103	132	131	108
	Union Memorial Hospital	7,484	6,712	5,849	6,498	6,949	6,852
	University of Maryland	15,376	15,722	13,794	13,875	14,772	15,486
	Total	88,742	83,860	75,518	78,699	77,286	72,904
Harford	Fallston General Hospital*	1,204	51	51	56	80	86
	Harford Memorial Hospital	2,077	2,740	1,796	2,678	2,994	2,476
	Total	3,281	2,791	1,847	2,734	3,074	2,562
Howard	Howard County General Hospital	3,583	2,844	2,517	2,207	2,503	2,814
	Taylor Manor Hospital	23,455	21,221	17,945	17,721	17,051	15,250
	Total	27,038	24,065	20,462	19,928	19,554	18,064
	CENTRAL MARYLAND TOTAL	186,884	177,101	162,011	173,355	174,450	159,652
Caroline		-	-	-	-	-	-
Cecil	Union Hospital of Cecil	329	3,028	2,616	2,404	1,978	2,015
Dorchester	Dorchester General Hospital	3,950	3,925	2,551	2,285	2,586	3,427
Kent	Kent & Queen Anne's Hospital	46	73	25	8	42	76
Queen Anne's		-	-	-	-	-	-
Somerset	E. W. McCready Memorial Hospital	4	-	32	12	14	27
Talbot	Memorial Hospital at Easton	1,193	675	72	52	79	78
Wicomico	Peninsula Regional Medical Center	3,153	2,512	2,099	2,543	2,923	3,181
Worcester	Atlantic General Hospital*	9	15	7	15	18	21
	EASTERN SHORE TOTAL	8,684	10,228	7,402	7,319	7,640	8,825
	MARYLAND TOTAL	288,974	270,381	241,826	288,079	273,513	264,627

*Hospital does not have designated psychiatric service.

Source: MHCC Hospital Discharge Abstract Database.

Appendix B

Trends in Psychiatric Discharges by County, Acute General and Private Hospitals, 1995 to 2000

Jurisdiction/ Local Health Planning Area	Hospitals	1995	1996	1997	1998	1999	2000
Allegany	Memorial Hospital of Cumberland*	28	38	32	16	22	18
	Sacred Heart Hospital	571	561	515	626	697	703
	Total	599	599	547	642	719	721
Carroll	Carroll County General Hospital	825	772	699	848	807	818
Frederick	Frederick Memorial Hospital	546	539	565	580	597	561
Garrett	Garrett County Memorial Hospital*	26	25	20	13	24	15
Washington	Brooklane Health Services	1,111	1,154	1,158	1,301	1,250	1,150
	Washington County Hospital	566	672	670	644	604	691
	Total	1,677	1,826	1,828	1,945	1,854	1,841
	WESTERN MARYLAND TOTAL	3,673	3,761	3,659	4,028	4,001	3,956
Montgomery	Holy Cross Hospital	329	226	181	191	86	32
	Montgomery General Hospital	1,098	975	956	977	1,000	1,110
	Potomac Ridge Treatment Center	1,124	1,081	815	950	948	1,050
	Shady Grove Adventist Hospital*	20	18	20	36	25	34
	Suburban Hospital	740	736	639	645	793	891
	Washington Adventist Hospital	1,441	1,461	1,507	1,533	1,591	1,596
	MONTGOMERY COUNTY TOTAL	4,752	4,497	4,118	4,332	4,443	4,713
Calvert	Calvert Memorial Hospital	500	491	417	476	448	471
Charles	Civista Medical Center*	14	6	8	12	14	6
Prince George's	Doctors Community Hospital*	9	12	9	6	12	16
	Fort Washington Medical Center*	2	2	5	-	2	6
	Laurel Regional Hospital	590	619	528	568	529	657
	Prince George's Hospital Center	1,139	1,010	817	1,051	1,070	1,290
	Southern Maryland Hospital Center	785	772	850	915	812	920
	Total	2,525	2,415	2,209	2,540	2,425	2,889
St. Mary's	St. Mary's Hospital	402	407	385	343	353	342
	SOUTHERN MARYLAND TOTAL	3,441	3,319	3,019	3,371	3,240	3,708
Anne Arundel	Anne Arundel Medical Center*	19	31	16	26	17	31
	North Arundel Hospital	751	643	636	581	619	698
	Total	770	674	652	607	636	729
Baltimore County	Northwest Hospital Center	26	33	35	23	29	23
	Franklin Square Hospital	754	793	998	1,133	913	1,176
	GBMC	54	36	43	45	61	92
	St. Joseph Hospital	503	394	538	544	613	582
	Shepppart Pratt Hospital	5,330	5,009	4,106	3,869	4,034	5,200
	Total	6,667	6,265	5,720	5,614	5,650	7,073

Jurisdiction/ Local Health Planning Area	*Hospitals*	1995	1996	1997	1998	1999	2000
Baltimore City	Bon Secours Hospital	12	16	20	9	449	410
	Childrens Hospital*	-	-	-	1	-	-
	Church Hospital	16	14	14	11	8	-
	Good Samaritan Hospital*	24	35	35	28	24	30
	Harbor Hospital*	27	16	15	14	20	20
	Johns Hopkins Bayview Medical Ctr.	732	801	744	750	795	891
	Johns Hopkins Hospital	1,802	2,030	2,025	2,026	2,412	2,422
	Kernan Hospital	1	-	1	-	-	-
	Liberty Medical Center*	2,034	2,283	2,003	2,148	1,039	-
	Maryland General Hospital	868	974	785	733	832	1,040
	Mercy Medical Center	176	166	97	46	19	23
	Sinai Hospital of Baltimore	554	811	1,060	1,169	1,262	1,304
	St. Agnes Hospital*	46	45	30	44	37	35
	Union Memorial Hospital	832	923	837	905	976	1,119
	University of Maryland	1,571	1,765	1,802	1,766	1,772	1,673
	Total	8,695	9,879	9,468	9,650	9,645	8,967
Harford	Fallston General Hospital*	171	18	19	22	40	47
	Harford Memorial Hospital	382	580	461	549	557	477
	Total	553	598	480	571	597	524
Howard	Howard County General Hospital	713	638	533	492	533	576
	Taylor Manor Hospital	1,382	1,053	966	942	986	1,412
	Total	2,095	1,691	1,499	1,434	1,519	1,988
	CENTRAL MARYLAND TOTAL	18,780	19,107	17,819	17,876	18,047	19,281
Caroline		-	-	-	-	-	-
Cecil	Union Hospital of Cecil	77	544	486	412	407	391
Dorchester	Dorchester General Hospital	470	471	474	383	542	647
Kent	Kent & Queen Anne's Hospital	18	20	8	4	12	14
Queen Anne's		-	-	-	-	-	-
Somerset	E. W. McCready Memorial Hospital	1	-	14	4	5	7
Talbot	Memorial Hospital at Easton	235	178	26	18	28	31
Wicomico	Peninsula Regional Medical Center	461	437	419	411	497	534
Worcester	Atlantic General Hospital	4	5	3	6	6	6
	EASTERN SHORE TOTAL	1,266	1,655	1,430	1,238	1,497	1,630
	MARYLAND TOTAL	31,912	32,339	30,045	30,845	31,228	33,288

*Hospital does not have designated psychiatric service.
Source: MHCC Hospital Discharge Abstract Database.

Appendix C

Average Length of Stay for Psychiatric Patients, Acute General and Private Hospitals 1995 to 2000

Jurisdiction/ Local Health Planning Area	Hospitals	1995	1996	1997	1998	1999	2000
Allegany	Memorial of Cumberland Hospital*	3.75	2.97	4.47	3.31	3.55	3.11
	Sacred Heart Hospital	8.29	7.19	6.17	7.04	6.26	5.80
	Total	8.07	6.92	6.07	6.95	6.18	5.73
Carroll	Carroll County General Hospital	6.96	5.76	6.18	5.59	6.70	7.01
Frederick	Frederick Memorial Hospital	6.82	5.14	4.96	5.68	5.52	6.33
Garrett	Garrett County Memorial Hospital*	2.62	2.36	2.30	1.38	1.96	2.40
Washington	Brooklane Health Services	8.09	7.42	7.87	8.68	10.69	7.55
	Washington County Hospital	6.36	6.03	4.77	4.22	4.34	4.99
	Total	7.51	6.91	6.73	7.20	8.62	6.59
	WESTERN MARYLAND TOTAL	7.34	6.39	6.23	6.58	7.29	6.47
Montgomery	Holy Cross Hospital	6.57	5.60	5.44	6.66	6.70	5.75
	Montgomery General Hospital	6.11	5.83	5.61	6.09	5.66	5.37
	Potomac Ridge Treatment Center	12.20	10.80	10.88	38.50	22.40	24.60
	Shady Grove Adventist Hospital*	4.70	2.44	2.75	4.00	6.48	5.00
	Suburban Hospital	6.91	6.92	6.50	6.69	6.05	5.64
	Washington Adventist Hospital	6.88	6.68	6.65	6.70	6.14	5.58
	MONTGOMERY COUNTY TOTAL	7.94	7.46	7.15	13.51	9.50	9.78
Calvert	Calvert Memorial Hospital	8.29	6.30	6.26	5.41	5.30	5.97
Charles	Civista Medical Center*	4.07	3.00	2.88	5.42	2.50	3.00
Prince George's	Doctors Community Hospital*	4.56	4.25	3.67	9.00	2.67	2.00
	Fort Washington Medical Center*	2.00	0.00	1.80	-	5.00	1.50
	Laurel Regional Hospital	7.93	7.94	7.02	6.50	4.60	5.16
	Prince George's Hospital Center	8.91	8.55	7.32	7.50	7.12	6.00
	Southern Maryland Hospital Center	8.19	7.44	6.20	6.57	6.62	6.20
	Total	8.44	8.01	6.79	6.94	6.38	6.82
St. Mary's	St. Mary's Hospital	8.01	7.43	6.60	6.10	6.14	5.70
	SOUTHERN MARYLAND TOTAL	8.35	7.68	6.68	6.63	6.19	6.60
Anne Arundel	Anne Arundel Medical Center*	4.37	2.94	3.25	3.04	5.00	2.97
	North Arundel Hospital	5.18	6.36	6.54	6.34	5.62	4.93
	Total	5.16	6.21	6.46	6.20	5.60	4.85
Baltimore County	Northwest Hospital Center*	3.54	4.33	3.20	2.52	3.07	2.70
	Franklin Square Hospital	10.92	8.97	8.13	7.33	6.21	5.01
	Greater Baltimore Medical Center*	2.76	4.72	2.84	4.51	3.11	3.54
	St. Joseph Hospital	8.18	7.76	9.71	10.44	9.69	10.53
	Sheppard Pratt Hospital	9.62	10.32	11.30	13.95	14.65	9.65
	Total	9.58	9.93	10.48	12.15	12.56	8.85

Jurisdiction/ Local Health Planning Area	Hospitals	1995	1996	1997	1998	1999	2000
Baltimore City	Bon Secours Hospital	6.92	3.81	3.45	3.00	5.94	5.42
	Childrens Hospital*	-	-	-	2.00	-	-
	Church Hospital	2.25	5.00	2.00	4.64	4.00	-
	Good Samaritan Hospital*	4.21	2.66	4.60	4.07	2.54	10.87
	Harbor Hospital*	3.41	2.75	3.20	3.43	2.05	3.20
	Johns Hopkins Bayview Medical Ctr.	7.68	6.79	7.40	7.34	5.55	5.79
	Johns Hopkins Hospital	16.06	13.43	12.91	13.05	11.36	11.59
	Kernan Hospital*	1.00	-	7.00	-	-	-
	Liberty Medical Center*	7.50	6.04	5.43	5.84	6.34	-
	Maryland General Hospital	8.32	6.91	7.37	8.37	8.18	6.73
	Mercy Medical Center	9.61	10.19	8.26	9.02	4.89	3.13
	Sinai Hospital of Baltimore	12.03	7.49	5.98	5.91	5.80	5.79
	St. Agnes Hospital*	3.89	3.71	3.43	3.00	3.54	3.09
	Union Memorial Hospital	9.00	7.27	6.99	7.18	7.12	6.12
	University of Maryland	9.79	8.91	7.65	7.86	8.34	9.26
	Total	10.21	8.49	7.98	8.16	8.01	8.13
Harford	Fallston General Hospital*	7.04	2.83	2.68	2.55	2.00	1.83
	Harford Memorial Hospital	5.44	4.72	3.90	4.88	5.38	5.19
	Total	5.93	4.67	3.85	4.79	5.15	4.89
Howard	Howard County General Hospital	5.03	4.46	4.72	4.49	4.70	4.89
	Taylor Manor Hospital	16.97	20.15	18.58	18.81	17.29	10.80
	Total	12.91	14.23	13.65	13.90	12.87	9.09
	CENTRAL MARYLAND TOTAL	9.95	9.27	9.09	9.70	9.67	8.28
Caroline							
Cecil	Union Hospital of Cecil	4.27	5.57	5.38	5.83	4.86	5.15
Dorchester	Dorchester General Hospital	8.40	8.33	5.38	5.97	4.77	5.30
Kent	Kent & Queen Anne's Hospital*	2.56	3.65	3.13	2.00	3.50	5.43
Queen Anne's							
Somerset	E. W. McCready Memorial Hospital	4.00	-	2.29	3.00	2.80	3.86
Talbot	Memorial Hospital at Easton*	5.08	3.79	2.77	2.89	2.82	2.52
Wicomico	Peninsula Regional Medical Center	6.84	5.75	5.01	6.19	5.88	5.96
Worcester	Atlantic General Hospital*	2.25	3.00	2.33	2.50	3.00	3.50
	EASTERN SHORE TOTAL	6.86	6.18	5.18	5.91	5.10	5.41
	MARYLAND TOTAL	9.06	8.36	8.05	9.34	8.76	7.95

*Hospital does not have designated psychiatric services.
Source: MHCC Hospital Discharge Abstract Database.

Appendix D

Trends in Average Daily Census, Psychiatric Services at Acute General and Private Hospitals

1995 to 2000

Jurisdiction/ Local Health Planning Area	Hospitals	1995	1996	1997	1998	1999	2000
Allegany	Memorial Hospital of Cumberland*	0	0	0	0	0	0
	Sacred Heart Hospital	13	11	9	12	12	11
	Total	13	11	9	12	12	11
Carroll	Carroll County General Hospital	16	12	12	13	15	16
Frederick	Frederick Memorial Hospital	10	8	8	9	9	10
Garrett	Garrett County Memorial Hospital*	0	0	0	0	0	0
Washington	Brooklane Health Services	25	23	25	31	37	24
	Washington County Hospital	10	11	9	7	7	9
	Total	35	35	34	38	44	33
	WESTERN MARYLAND TOTAL	74	66	62	73	80	70
Montgomery	Holy Cross Hospital	6	3	3	3	2	1
	Montgomery General Hospital	18	16	15	16	15	16
	Potomac Ridge Treatment Center	38	32	24	100	58	71
	Shady Grove Adventist Hospital	0	0	0	0	0	0
	Suburban Hospital	14	14	11	12	13	14
	Washington Adventist Hospital	27	27	27	28	27	24
	MONTGOMERY COUNTY TOTAL	103	92	81	160	116	126
Calvert	Calvert Memorial Hospital	11	8	7	7	7	8
Charles	Civista Medical Center*	0	0	0	0	0	0
Prince George's	Doctors Community Hospital*	0	0	0	0	0	0
	Fort Washington Medical Center*	0	0	0	0	0	0
	Laurel Regional Hospital	13	13	10	10	7	9
	Prince George's Hospital Center	28	24	16	22	21	21
	Southern Maryland Hospital Center	18	16	14	16	15	16
	Total	58	53	41	48	42	46
St. Mary's	St. Mary's Hospital	9	8	7	6	6	5
	SOUTHERN MARYLAND TOTAL	79	70	55	61	55	59
Anne Arundel	Anne Arundel Medical Center*	0	0	0	0	0	0
	North Arundel Hospital	11	11	11	10	10	9
	Total	11	11	12	10	10	10
Baltimore County	Northwest Hospital Center*	0	0	0	0	0	0
	Franklin Square Hospital	23	19	22	23	16	16
	Greater Baltimore Medical Center*	0	0	0	1	1	1
	St. Joseph Hospital	11	8	14	16	16	17
	Sheppard Pratt Hospital	140	142	127	148	162	137
	Total	175	170	164	187	194	171

Jurisdiction/ Local Health Planning Area	Hospitals	1995	1996	1997	1998	1999	2000
Baltimore City	Bon Secours Hospital	0	0	0	0	7	6
	Childrens Hospital*	0	0	0	0	0	0
	Church Hospital	0	0	0	0	0	0
	Good Samaritan Hospital*	0	0	0	0	0	1
	Harbor Hospital*	0	0	0	0	0	0
	Johns Hopkins Bayview Medical Ctr.	15	15	15	15	12	14
	Johns Hopkins Hospital	79	75	72	72	75	77
	Kernan Hospital	0	0	0	0	0	0
	Liberty Medical Center*	42	38	30	34	18	0
	Maryland General Hospital	20	18	16	17	19	19
	Mercy Medical Center	5	5	2	1	0	0
	Sinai Hospital of Baltimore	18	17	17	19	20	21
	St. Agnes Hospital*	0	0	0	0	0	0
	Union Memorial Hospital	21	18	16	18	19	19
	University of Maryland	42	43	38	38	40	42
	Total	243	230	207	216	212	200
Harford	Fallston General Hospital*	3	0	0	0	0	0
	Harford Memorial Hospital	6	8	5	7	8	7
	Total	9	8	5	7	8	7
Howard	Howard County General Hospital	10	8	7	6	7	8
-	Taylor Manor Hospital	64	58	49	49	47	42
-	Total	74	66	56	55	54	49
	CENTRAL MARYLAND TOTAL	326	303	268	278	274	256
Caroline		-	-	-	-	-	-
Cecil	Union Hospital of Cecil	1	8	7	7	5	6
Dorchester	Dorchester General Hospital	11	11	7	6	7	9
Kent	Kent & Queen Anne's Hospital*	0	0	0	0	0	0
Queen Anne's		-	-	-	-	-	-
Somerset	E. W. McCready Memorial Hospital	0	0	0	0	0	0
Talbot	Memorial Hospital at Easton*	3	2	0	0	0	0
Wicomico	Peninsula Regional Medical Center	9	7	6	7	8	9
Worcester	Atlantic General Hospital*	0	0	0	0	0	0
	EASTERN SHORE TOTAL	24	28	20	20	21	24
	MARYLAND TOTAL	606	559	487	592	545	536

*Hospital does not have designated psychiatric service.

Source: MHCC Hospital Discharge Abstract Database.